SAN FRANCISCO PUBLIC LIBRARY
3 1223 06155 2627

5th CLOSED STACKS

San Francisco Public Library

GOVERNMENT INFORMATION CENTER
SAN FRANCISCO PUBLIC LIBRARY

REFERENCE BOOK

Not to be taken from the Library

3 1223 06155 2627

Digitized by the Internet Archive
in 2012 with funding from
California State Library Califa/LSTA Grant

http://archive.org/details/minutes1993sanf

HIV HEALTH SERVICES PLANNING COUNCIL

January 11, 1993

The Agenda and Minutes of this meeting are missing.

San Francisco Public Library
Government Information Center

SF
H22
#3
1/25/93

SF

DOCUMENTS DEPT
FEB 2 1993
SAN FRANCISCO
PUBLIC LIBRARY

HIV HEALTH SERVICES PLANNING COUNCIL
January 25, 1993
4:30-7:30 p.m.

Members Present: Sandra Hernandez, Marcy Fraser, Estela Garcia, Les Hanson, Gerald Lenoir, Steve Lew, Kent Macdonald, J.B. Molaghan, Bob Nelson, Elliot Ramos, Eric Rofes, Mike Shriver, Laura Thomas, Jerry Windley, Mary Jane Wood

Members Absent: Reggie Williams, Pat Christen, Yvonne Frazier, Jaime Geaga, Karen Hembry, Gifford Leoung, Scott Miller, Patricia Underwood

Staff Present: Mitch Katz, Sophia Chang, Valerie Dorr, Judith Weld, Jon Dean Green

I. Roll Call

Minutes

Roll Call was taken as above.

II. Review of Agenda and Minutes

The minutes of the January 11, 1993, meeting were approved with changes. Gerald Lenoir abstained from the vote. Under Section IV, the last sentence should read: "During the appropriation cycle, Communities Advocating Emergency AIDS Relief will by lobbying for CARE *Titles I-IV* (not prevention services)." Under Section IX, a final sentence should be added which should read: "A report will be made to the Planning Council by the end of February."

III. General Comment

Laura Thomas stated that the Long Range Planning Subcommittee had met. The next meeting of the Subcommittee will be 2:30 p.m., February 8, 1993, at 1540 Market Street.

Mike Shriver announced that an NIH reauthorization bill has been introduced. There is a move afoot to reform HIV services overseen by HRSA/NIH/CDC.

Jerry Windley announced a legislative proposal to form a Joint Task Force on the HIV Epidemic to advise the Board of Supervisors and Mayor. (See attached document.) Mr. Windley asked Planning Council members to review the document and contact him at Supervisor Alioto's Office in the afternoons at 554-7788 for comment and information on the legislative hearing date. Mr. Windley stated that a change in language was being considered to assure the ordinance had appropriate community representation. Sandra Hernandez stated that the Department had offered to have AIDS Office advisory co-chairs sit on the proposed Task Force.

IV. Update on DPH Budget/General Fund

Mitch Katz presented the initial FY 93-94 General Fund budget proposal from the AIDS Office to meet its target budget reduction. (See attached document.) Dr. Katz stated that the Mayor has directed all departments to absorb cost-of-living increases. For the Department of Public Health (DPH) this translates to a $30 million cut. The Mayor's request is that the priority should be administrative

4 48533 SFPL : ECONO JRS
90 SFPL 02/03/02 56

reductions to minimize any impact on direct services. In order to meet the target FY 93-94 budget cuts, the AIDS Office is to reduce its budget by $1.5 million; the majority of this "cut" is being met by the closure of the Center for Positive Care. Remaining health services reductions will occur through the consolidation of like services. Dr. Katz stated that a meeting was held with providers whose contracts are being considered for consolidation. Estela Garcia stated that it is presumptuous for the Bielenson documents to say, "No service impact." The documents should read, "Impact unknown."

Gerald Lenoir stated he attended the consolidation meeting and had several concerns. The DPH lacked an overall plan for consolidation. How will the process proceed without a vision of where the system should be? Mr. Lenoir stated that the initial proposal was to consolidate all ten contracts into one or two contracts. This seemed too precipitous. The majority of the agencies involved in the consolidation process did not have the financial resources necessary to act as the fiscal agent. Mr. Lenoir questioned the implications for People of Color and small community-based organizations (CBOs).

Q-Wasn't the $1,025,981 being saved by the closing of the Center for Positive Care (CPC) set aside for the DPH in primary care? A-Supervisor Migden set aside $1 million in AIDS services in a supplemental budget. The DPH has developed a staffing plan for those monies. There has been no indication from the Mayor or Board of Supervisors if the supplemental budget will be approved.

Q-Who has reviewed the consolidation proposal? A-The People of Color and Prevention Advisory Committees.

Q-Where is the expectation of savings in the consolidation proposal? A-The hope is that monies will be saved in administration through fiscal efficiency.

Eric Rofes stated that to achieve consolidation of services, it often takes an infusion of funds to eventually achieve consolidation and cost savings. Sandra Hernandez stated that one-time funds might be looked at to help consolidate services.

Q-The proposed reductions do not reflect City and State cuts in funding? A-No, the budget only reflects reductions to absorb the increased cost of services that will be incurred in the new fiscal year due to inflation.

Gerald Lenoir stated that the undercutting of administrative expenses could jeopardize the viability of smaller agencies. The DPH is being asked to respond quickly to political pressure rather than in a planned manner. There will be a severe impact on morale. Sandra Hernandez stated that the Mayor receives different messages from disparate camps within his offices. The budgetary arm states that monies can be saved through greater efficiency in services. The policy arm states that AIDS services should not be reduced. The budget instructions the DPH follows are issued by the budgetary arm of the Mayor's office. There are no longer any low priority services to cut to preserve higher priority services.

Estela Garcia stated that the providers have enough integrity and intelligence to come together and decide on reductions. There is a question of process and how providers can be more involved with budgetary decisions. The idea that administrative cuts are not reflected in service cuts is a myth. Ms. Garcia stated that consolidation efforts in other divisions within DPH have led to service cuts.

The consensus of the Planning Council was that it should articulate the policies and principles for HIV services to advise the Mayor and also invite Mayor Jordan to attend the Planning Council to hear its concerns.

Mitch Katz stated that the work furlough program put forward by the DPH had yet to be implemented. Sandra Hernandez stated that a five-day mandatory furlough had been approved by the Civil Service, which the unions objected to. A voluntary furlough is being attempted Citywide. Dr. Hernandez stated that General Fund contractors are being asked to also reduce their contracts in an amount equivalent to a five day work furlough.

Dr. Hernandez stated that the Planning Council must concretely frame its stance on the first round of budget cuts. The AIDS leadership must speak to streamlining and efficiencies. Gerald Lenoir stated that the AIDS leadership must consider what are the needs of San Francisco, how to prioritize those needs and how the revenues should be raised to provide the services.

The consenus of the Planning Council was that the target service reductions are not just administrative cuts but will be reflected in service cuts. Eric Rofes stated that the long range goal of CBOs and the AIDS Office must be to look to a partnership that maximizes efficiencies to better meet the high priority needs of persons with HIV. The Planning Council stated that it was committed to finding ways to effect cost savings without decomposing the system of HIV care.

V. Update on Title II Working Group Meeting

Jon Dean Green spoke on the Title II Working Group Meeting in Santa Rosa. The three day meeting was a statewide forum for consensus on expenditure of Title II monies for California. For Y03, California will receive $17,183,378. Following are the initial allocations for Y03:

Category	Y02	Y03
Consortia	~7,700,000	8,591,689
Administration, Planning, Evaluation	~1,500,000	1,718,338
Insurance Continuation Program (CARE HIPP)	600,000	600,000
AIDS Drug Assistance Program (ADAP)	~4,600,000	~5,070,000
Home- and Community-Based Care Programs	~1,000,000	~1,200,000

Additionally, $300,000 will be set aside for "Tier II Epicenters", which are non-Title I jurisdictions which have a rate of at least 70 incidences per 100,000; and at least 300 cumulative AIDScases. Counties meeting this definition are: Riverside, Sacramento, Santa Barbara, Santa Clara, Solano, and Sonoma. The allocation of the $300,00 will be based on living persons with AIDS.

The next working group meeting will be February 11, 1993 in Santa Barbara, California.

VI. Update on the Discontinuation of DPH Pilot Care Project

Janet Nasser, Westside Community Mental Health, stated that in October 1992, the AIDS Office, the State Office of AIDS and Westside met and agreed to the transfer of the City Pilot Care program to Westside to effect more efficient use of State grant funds. The City transferred its Pilot Care program to Westside to consolidate services and achieve cost savings and maximize direct services to clients.

The consolidation of services gave Westside a case load of 114 clients. Subsequent to responding to the State RFP for home- and community-based care, Ms. Nasser stated that on January 4, 1993, Westside received a letter stating that beginning July 1, 1993 it would only be receiving $315,000 to cover 49 clients. The funds that had previously covered clients in the City program had been used by the State to fund four new programs in other localities. Dr. Hernandez stated that she has articulated her objection to this decision to the State Office of AIDS. Dr. Hernandez has requested clarification from Wayne Sausedo on the funding decision. Dr. Hernandez has also reinvited the State to send a representative to the Planning Council to better coordinate State and City HIV service efforts.

Q-Has Westside appealed the decision? A-Yes. The appeal was denied.

VII. Review of the RFP Process

Judith Weld, RFP Coordinator, began an overview of the Y03 RFP process. (See attached document.) Sophia Chang stated that the rebid process did not accomplish what the Planning Council had originally envisioned. The intent of the Planning Council with its rebidding decision had been to allow for healthy competition and increase the number of People of Color providers. There was no increase in the People of Color providers, and only one rebid service had a competitor. The process also took an exorbitant amount of CBO/Planning Council/AIDS Office time. Dr. Chang stated that while developing "fair processes," the Planning Council had moved away from planning. There is a renewed need to look at the service needs of underserved populations.

Q-Is it possible for agencies to turn in their proposals early to have the forms checked for completeness? A-It should be. Ms. Weld will check further with the Office of Contracts Management. AIDS Office staff will do an analysis of where the RFP process allows for flexibility and report back to the Planning Council.

Sandra Hernandez asked the Planning Council to review the memos distributed by Ms. Weld. If there were any comments for Ms. Weld, she can be reached at 554-9044.

Sophia Chang announced that the City should be informed in early March of the amount it would be receiving in the Supplemental Grant. Dr. Chang stated that for Y04 the Planning Council must not assume that currently existing services will continue to be funded. The entire continuum of care must be examined and re-evaluated.

X. Public Comment

Eric Rofes in his capacity as Executive Director of Shanti, not as a member of the Planning Council, asked the Planning Council to examine the RFP process so that it will know what it is funding and what programs it is cutting. The re-bid proposals that Shanti submitted for Latino and youth congregate services went unfunded. This then leaves a gap in services for these two populations. Mr. Rofes stated that the Planning Council process does not look at how the continuum of services are being cut, augmented or transitioned. (See attached document.)

01263gaa

HIV HEALTH SERVICES PLANNING COUNCIL

February 8, 1993

The Agenda of this meeting is missing.

San Francisco Public Library
Government Information Center

SF
H22
#2
2/8/93

SF
Minutes

DOCUMENTS DEP
FEB 16 1993
SAN FRANCISCO
PUBLIC LIBRARY

HIV HEALTH SERVICES PLANNING COUNCIL

February 8, 1993
4:30 - 7:30 p.m.

Members Present: Sandra Hernandez, Reggie Williams, Pat Christen, Marcy Fraser, Estela Garcia, Les Hanson, Gifford Leoung, Steve Lew, Kent Macdonald, Scott Miller, Bob Nelson, Elliot Ramos, Eric Rofes, Mike Shriver, Laura Thomas, Patricia Underwood, Jerry Windley

Members Absent: Yvonne Frazier, Jaime Geaga, Karen Hembry, Gerald Lenoir, J.B. Molaghan, Mary Jane Wood

Staff Present: Sophia Chang, Bill Haskell, Valerie Dorr, Judith Weld, Jon Dean Green

I. Roll Call

Roll Call was taken as above.

II. Review of Agenda and Minutes

The minutes of the January 25, 1993 meeting were approved.

III. General Comment

Reggie Williams announced that there will be a regional meeting on HIV/AIDS for Northern California and Northern Nevada on February 16, 1993, at the Parc Oakland Hotel. The meeting is to discuss the Federal AIDS agenda.

Pat Christen announced that the Senate Subcommittee on Appropriations has been invited to San Francisco for a CARE site visit on April 7 and 8. She asked that CARE funded agencies who are able to show how their services are provided without breaching client confidentiality to contact her. This will enable us to show the impact of CARE funds in San Francisco.

Eric Rofes announced that the Subcommittee on Long Range Planning had met for its second of three meetings. The Subcommittee's proposal will be presented at the February 22, 1993, Planning Council meeting. Mr. Rofes stated that the Subcommittee will be using a two step process focused on services. The Subcommittee will use the DPH mission statement presented by Dr. Baxter as a basis for policy and values and what the HIV services system should reflect. The Subcommittee will use the above as a foundation on how the HIV services system should serve persons with HIV and how to overcome barriers to care. The Planning Council will need to examine its resources and time commitments to implement any recommendations from the Subcommittee.

Michael Shriver announced that agencies will be receiving a formal letter from the Cities Advocating Emergency Aids Relief (CAEAR) asking agencies, where possible, to contribute funding to the CAEAR lobbying effort. CAEAR will be working on the House of Representatives markup at the end of February, beginning of March.

Valerie Dorr announced that the Executive Committee of the Department of Public Health (DPH) had made the decision to not request any General Fund (GF) reductions from contractors in the current fiscal year. The DPH will be moving forward with mandatory work furloughs for Civil Service employees funded through Ad Valorem monies.

IV. Routine Rebidding and Consolidation of Contract Exhibits

Judith Weld referred Planning Council members to the memorandum distributed at the last Planning Council meeting regarding proposed consolidation of CARE contract exhibits and revisions to the rebidding process (January 8th memo attached). Ms. Weld stated that the routine rebidding process was not working. The rebidding had not accomplished its stated purpose--increasing competition for services and/or increasing the percentage of funds to People of Color agencies. Sophia Chang stated that by consolidating contract exhibits, agencies would have their paperwork reduced for monitoring and quarterly reports.

Ms. Weld stated that the Planning Council should consider rebidding selectively and appropriately. In the most recent RFP, there was only one proposal for rebid services that had a competitive proposal. The process took an enormous amount of CBO, AIDS Office, and Review Team time. Ms. Weld stated that the DPH as a whole is moving away from routine rebidding.

Q-What does it mean to consolidate exhibits? A-Program Managers will negotiate exhibit consolidation. The AIDS Office will still be able to track information by treatment modality. Consolidation will allow for a reduction in monitoring and quarterly reporting.

Eric Rofes stated that the Planning Council had informed agencies that went out to routine rebid in Y02 that the rebidding was not punitive but rather a part of routine rebidding of all contracts. If the Planning Council decides to reverse its decision to rebid the remainder of Y02 services in Y03, then the decision must be announced to the community along with the reasons for the change in policy.

Sophia Chang stated that a concomitant piece to the rebidding issue is that if AIDS Office staff did not have to concentrate on another massive rebidding effort, it could spend more time performing program review and management. The Program Managers and Review Teams could concentrate on contracts that are failing to meet the needs of the targeted populations and where appropriate, funding could be reallocated. Dr. Chang stated that in Y04, the Planning Council will need to reconsider the way in which it has prioritized services. She wants the Planning Council to examine the entire continuum of care and reprioritize the whole system of services. The Supplemental Application no longer makes sense from a planning process standpoint. It is perpetuating an overly decentralized system through its lack of overall prioritization of essential HIV services. Dr. Chang stated that the Planning Council will not be able to assume that because a service was funded in Y01-Y03, that it will continue to be funded. The Planning Council must look at all services. This may lead to the defunding of some services if those services are not as essential as other services. Planning Council priorities would determined the funding of services.

Q-Why does the Planning Council need to make a decision now on routine rebidding and consolidation of services? A-The AIDS Office is preparing to move into contract negotiations with providers. A Planning Council decision on routine rebidding (affects the ability of the AIDS Office to combine contract exhibits), some of which might be routinely rebid in Y04.

Sandra Hernandez stated that in the experience of the DPH, routine rebidding only leads to a new provider in 2% of cases. The original Health Commission decision that called for routine rebidding was an attempt to encourage agencies not providing HIV services to look at delivering HIV services. With the advent of funding for HIV services through CARE and other funding mechanisms, the majority of agencies that can and should provide HIV services, do provide HIV services. Dr. Hernandez asked the Planning Council if it had any compelling reason to routinely rebid CARE services.

Pat Underwood stated that routine rebidding did not effect service provision. It creates a tremendous amount of work for all parties involved. The Planning Council needs to move towards streamlining the process. Dr. Hernandez added that the Planning Council deciding to consolidate contracts and move away from routine rebidding does not preclude it from a decision to rebid services where ever it deemed rebidding necessary.

Eric Rofes stated that it will take a great deal of courage for the Planning Council to move to a system that could conceivably defund existing services and reprioritize to meet new needs. The Planning Council must be brave enough to take on this task. Dr. Hernandez stated that the Planning Council had taken a great deal of public testimony on defunding decisions and second and third guessed itself. True long term planning and prioritization will be difficult. It will be hard to defund an agency that has a good monitoring report because it might not deliver a priority services.

Estela Garcia stated she supported the recommendations regarding consolidation and rebidding. It reduces the workload on agencies and strikes her as an effective means of streamlining the process. The Planning Council must examine the issue and make a decision. It must also make clear to the community that the decision came from the Planning Council and was not just an AIDS Office directive.

A) The following motion was passed by the Planning Council with Pat Christen, Kent Macdonald, Scott Miller, Eric Rofes and Michael Shriver abstaining.

<u>To approve the recommendations contained in the January 8, 1993, memo regarding proposed consolidation of CARE contract exhibits and revisions to the rebidding process.</u>

V. <u>Review of RFP Process</u>

Eric Rofes stated that he was concerned about the housing review team recommendation to set aside funds for the housing network. Mr. Rofes contended that decisions concerning funding set asides should be made by the Planning Council and not review teams. Mr. Rofes expressed some concerns that review teams might not necessarily hold to the same priorities as the Planning Council. Sandra Hernandez stated that review teams could be directed by the Planning Council that instead of setting aside funds, review teams could send forward to the Planning Council the information that it did not receive a competitive proposal for a Planning Council priority and request the Planning Council review its options. The Planning Council would have to bear in mind the issue of conflict of interest.

Sophia Chang stated that a problem with the routine rebidding for Y03 was that the Planning Council did not explicitly state that the rebid line items were a priority service. Dr. Chang stated that if the Planning Council does take on the issue of planning as she outlined above, then this problem will be avoided. For example, the Planning Council could state that its priority in housing was for Youth and Latino services.

Michael Shriver stated that he was uncomfortable with the Planning Council second guessing review team recommendations. The Planning Council should not diminish its trust in review teams. Planning Council members sit on review teams and part of their duty is to remind the review team of the Planning Council's overall priorities. Dr. Hernandez stated that there is a clear distinction between the mandate of review teams and the Planning Council. One problem is that Planning Council members who sit on review teams, monitoring teams and subcommittees do not speak to the "whats and whys" of their decisions when the Planning Council meets as a whole.

Sophia Chang stated that if the Planning Council moves to a streamlined process it will need to: a) be explicit that it deems certain services to be priorities with review teams subsequently recommending proposals that meet the services needs, and b) a mini-report will be needed from each review team on its decisions for the service category considered. The Planning Council must also consider how many times it will bid a service. If there are no competitive proposals in the first round, will the Planning Council rebid the service a second or third time? Michael Shriver stated that the Planning Council must be flexible without being haphazard in its decisions on prioritization and bidding. Dr. Chang added that part of the reason for the rush in the Y03 bidding process was the Supplemental Application was due a full month earlier than it had been in the prior two years. If the Planning Council builds in more decision time during the bidding process, this then backs into the time required for the monitoring process.

Laura Thomas cautioned that the Planning Council must not speak in absolutes. There can be a conflict between Planning Council priorities and bad proposals. A lower priority service might have a great proposal and a high priority proposal could be inferior. Does this mean the inferior proposal should be funded because it is a higher priority?

Sophia Chang stated that in the Supplemental Application, HRSA had ~17 service categories. If the Planning Council moved to a similar system, it would make it easier to break apart a service category such as Psychosocial services and rank Legal Services and Spiritual Counseling at very different places on the priority list. Eric Rofes stated that this related to issues of planning. His preference is that the Planning Council examine the whole system. How does Psychosocial Services or Housing relate to the other parts of the system. Mr. Rofes suggested that Planning Council members without conflict could be designated on review teams as experts on certain subjects and provide information on how review team decisions are impacting the entire system.

Judith Weld stated that she would prepare a draft revised RFP process for the Planning Council to review. Ms. Weld suggested that Planning Council members could provide feedback on it before it came to the full body. Eric Rofes and Kent Macdonald volunteered to review the document. Ms. Weld asked anyone else having suggestions or comments on the RFP process to call her at 554-9044.

Q-What will be the next step as the Planning Council did not reach its goal for funding percentages to People of Color agencies? A-The RFP process was changed without any significant effect. The Planning Council must consider whether it set reasonable targets. Is the lack of new proposals a matter of further technical assistance being needed? Dr. Hernandez stated that it was probably a multifactoral issue. Dr. Hernandez stated that the percentage of funding to People of Color agencies does not take in to account the high cost of providing housing or primary care services and how many People of Color agencies provide these services. It also does not take into account DPH services to People of Color. The AIDS Office could initiate a survey of People of Color agencies on why more did not apply for CARE funds.

VI. Review of Monitoring Process

Dr. Hernandez stated that as no members of the Subcommittee on Evaluation were present, the Planning Council could ask the Subcommittee to review the monitoring process after considering information from the DPH process that is examining monitoring protocols and the Subcommittee report back its recommendations to the full Planning Council.

Laura Thomas stated that criteria for defunding of agencies must be delineated. At what point does the Planning Council decide that there will be no further action taken to remedy a situation and defund an agency? Sandra Hernandez stated that defunding recommendations can be from several sources. A defunding recommendation may come out of a monitoring, or it might be based on staff recommendation in or not in conjunction with a monitoring. As actual monitoring visits have confidential information presented to either the team or staff, the full Planning Council may not have available to it privileged information. The Planning Council will need to examine defunding recommendations, make a decision, and stand up to their decision. Bill Haskell stated that staff are working on making contract narratives more clear to prevent agencies from being penalized twice for the same difficulty. Dr. Hernandez stated that review teams must look at agencies as a gestalt. The agency must be examined as a whole and additionally, programs must be looked at specifically.

VII. Review of Grievance Procedure

(Refer to attached revised document, Subcommittee on Evaluation - Defunding Process)

Q-How do agencies appeal a monitoring? A-All agencies are encouraged to respond to a monitoring in writing. These responses are then attached and made a part of the monitoring report. Judith Weld stated that the question she was hearing from the Planning Council was how an agency appealed the actual number rating it might receive. Sandra Hernandez responded by stating that most agencies were concerned in the prior round of monitorings due to the issue of rebidding. Since routine rebidding was no longer a consideration, agencies may have far fewer concerns. There will still however be a concern expressed by agencies over ratings that are so low a review team recommends defunding. This will be handled by the process delineated in the Grievance Procedure.

VIII. Update on Copayment Consultant

Sophia Chang stated the consultant for the copayment system has been identified. The consultant will review copayment systems for reimbursement throughout the system. In keeping with the Planning Council intent to maximize dollars, Dr. Chang would like the consultant to examine what services are potentially reimbursable by MediCal, and how agencies must go about being reimbursed. Dr. Chang would like for the copayment consultant to speak with the Planning Council so that they are clear on the Planning Council's intentions. There should be a Planning Council subcommittee to advise the consultant. Dr. Chang stated that Herman Levias of the Reimbursement Unit of the AIDS Office staff will be holding a training for HIV service providers on March 3, 1993, regarding Medi-Cal eligibility. Marcy Fraser, Bob Nelson, Laura Thomas and Jerry Windley volunteered to sit on the subcommittee that will advise the consultant.

IX. Date for People of Color Discussion

Jon Dean Green stated that the two persons who had been asked to facilitate the People of Color discussion held classes on Monday evenings. Mr. Green asked that any Planning Council members who knew of appropriate persons to ask to facilitate the meeting tentatively scheduled for March 8, 1993, to contact him at 554-9060.

X. Public Comment

(Please refer to enclosed handout.)

Kevin McGirr, Operation Concern, stated that his program is moving into its third year of CARE funding. Operation Concern provides mental health services to multidiagnosed clients. They rebid on a contract for primary care services for mental health. This rebid service was a contract that shared support to two other contracts, including one with A.I.D.S. The contract provides a psychiatrist and psychiatric nurse. Operation Concern will now have to refer clients out, thereby fragmenting service to this population.

Mr. McGirr asked if there was any way to fund these types of services. Sophia Chang stated that the Planning Council did not expect to receive enough monies to cover programs recommended for funding. Dr. Hernandez stated that the process was not appealable except on process.

Q-What is CPMC's commitment to the program? Will it fund any of these services? A-No.

Q-Will the $30,000 referred to in the letter cover services at both sites? A-No, just at Operation Concern.

Glenda Hope, Tenderloin AIDS Resources Center (TARC), stated that she had come to the Planning Council to address her concern over the cost and time commitment required of agencies to comply with Federal requirements around a full scope audit. The full scope audit is a severe burden on smaller CBOs. Ms. Hope questioned if this is the way the Planning Council wanted to spend CARE dollars. Ms. Hope would like the Planning Council to take part in a statement to Congress on how the requirements could be made less burdensome without losing the information Congress would like to have. Ms. Hope will convene a group to discuss the issue. Ms Hope stated that when the costs of complying with the full scope audit are examined nationwide, the cumulative costs become enormous.

To clarify, Judith Weld stated that Ms. Hope was referring to the requirements set forth in the Office of Management and Budget circular A-133. Under OMB A-133, once an agency passes a threshold dollar amount, the agency is required to have an audit performed by a certified public accountant that reviews the scope of compliance with Federal requirements such as a drug free workplace.

Q-What is the cost of performing a full scope audit? A-Ms. Weld stated that the cost is dependent upon the size of the agency's budget. However, one agency she is familiar with that has approximately 50 staff went from an audit that cost ~$8,000 to $15,000 due to the requirement.

Pat Christen stated that the full scope audit was a burden to large agencies also. It takes an enormous amount of money and staff time. For the San Francisco AIDS Foundation, the cost will run ~$80,000 to $100,000 in pro bono costs. Ms. Christen would like to see the IRS reverse its decision.

DOCUMENTS DEPT
FEB 16 1993
SAN FRANCISCO
PUBLIC LIBRARY

SF
H22
#1
2/22/93

HIV HEALTH SERVICES PLANNING COUNCIL
February 22, 1993
25 Van Ness, Third Floor Conference Room
4:30 - 7:30 p.m.

AGENDA

I. Roll Call

II. Review of Agenda and Minutes

III. General Announcements

IV. Review of 1992 HOPWA Awards

V. Prioritization of 1993 HOPWA Funds

VI. Report of Subcommittee on Long Range Planning

VII. Public Comment

02103gaa

AIDS OFFICE
25 VAN NESS AVENUE, SUITE 500
SAN FRANCISCO, CA 94102 - 6033
415 - 554-9000
FAX 415 - 431-7547

DOCUMENTS DEPT.
MAR 05 1993
SAN FRANCISCO
PUBLIC LIBRARY

HIV Health Services Planning Council
February 22, 1993
4:30 - 6:15 p.m.

Minutes

Members Present: Marcy Fraser, Estela Garcia, Les Hanson, Gerald LeNoir, Steve Lew, Scott Miller, Bob Nelson, Eric Rofes, Laura Thomas, Patricia Underwood, Jerry Windley, Mary Jane Wood, Sandra Hernandez

Members Absent: Pat Christen, Yvonne Frazier, Karen Hembry, Gifford Leoung, Kent Macdonald, J.B. Molaghan, Mike Shriver, Reggie Williams

Staff Present: Sophia Chang, Bill Haskell, Valerie Dorr, Mark Morewitz, James Loyce, Kandyce Collins

I. Roll Call

Roll Call was taken as above.

II. Review of Agenda and Minutes

The minutes of the February 8, 1993 meeting were approved. Abstentions: Estela Garcia, Mary Jane Wood

III. General Comment

Jerry Windley announced that a Health & Public Safety meeting of the Board of Supervisors has been called for March 24, 1993 to address issues related to TB and HIV youth services. The meeting will be held in City Hall, in room 228. He encouraged Council members to communicate with Supervisors Angela Alioto and Barbara Kaufman about these issues before their departure for Washington DC, to lobby for CARE funding on March 9 and 10, 1993.

Bob Nelson announced that a regional meeting on HIV/AIDS Policy took place on February 16, 1993 to develop a federal AIDS agenda for the Clinton administration. Delegates from various regional meetings will gather in Washington DC on February 28, 1993 to discuss this agenda further.

Jerry Windley asked to put two items on the Planning Council agenda:

1. To discuss sending a letter, regarding the Nichels Amendment, to Congresswoman Nancy Pelosi, Senators Ted Kennedy, Barbara Boxer and Diane Feinstein. This amendment codifies into law the Executive Policy of restricting travel and immigration based on HIV status.

2. To invite Mayor Jordan, the President of the Board of Supervisors, and Budget Committee to the Planning Council meeting scheduled for March 22, 1993 to discuss the City budget.

In regard to the request for a letter to be sent concerning the Nichels Amendment, Sandra Hernandez stated that, by definition, the Planning Council cannot take part in any lobbying effort. However, individual members are encouraged to send separate letters.

Marcy Fraser inquired about the appropriate timing of asking the Mayor and Board of Supervisors to a Planning Council meeting in relation to the Joint Task Force being formed by Supervisor Migden. Dr. Hernandez stated that the March 22, 1993 date would be most appropriate.

A) The following motion was passed by the Planning council.

To send an invitation to the Mayor Jordan, the President of the Board of Supervisors and the Budget Committee for the March 22, 1993 Planning Council meeting to discuss budgeting issues.

James Loyce discussed the allegations concerning mismanagement of funds at AIDS Indigent Direct Services (A.I.D.S.). He is meeting with Board of Directors to discuss a programmatic audit which will begin in early March, 1993. The Controller's Office is awaiting a full review by an independent auditor for the 18 month period from July 1991 through January 1993 to be completed before any further review. All staff employed at A.I.D.S. during this period will be interviewed. By the end of March, the audit process will be completed and a full report will be presented to the Planning Council. Sandra Hernandez encouraged members of the Planning Council to refer any calls pertaining to this issue from the media to the AIDS Office. Bob Nelson expressed concern over the potential gap in money management services in the Tenderloin should there be a discontinuation of funding for A.I.D.S.

Sophia Chang asked if the development of RFPs for the HIV Housing Resources/Referral Network and Youth Psychosocial Services should be included in the review of the entire RFP process. Laura Thomas stated that the above mentioned RFPs should be developed and issued using the process currently in place and that the consolidation RFPs need a more extensive review.

Dr. Hernandez introduced Steve Roger from the State Office of AIDS. Mr. Roger will attend Planning Council meetings on an ongoing basis.

IV. Report of Subcommittee on Long Range Planning

A proposal on strategic planning for services was distributed. (February 22, 1993 Proposal attached)

In response, the Planning Council expressed the need to be proactive in future planning efforts. This would include taking prevention/education providers into consideration, to facilitate transition into care. Members discussed the need to analyze the current model of service from a client centered and culturally sensitive point of view. Coordinated, centralized case management/advocacy and clustering of services were concepts mentioned as possibilities in a future model. Also discussed was the possible effect of managed care on

the current model. It was agreed that this effort would not include a needs assessment or an evaluation of gaps in service.

Dr. Hernandez stated that the Planning Council is mandated by definition to do planning and the AIDS Office staff will support the Council's efforts. The AIDS Office will assess the possibility of staffing this subcommittee. She also made it clear that system reform is a primary priority and asked members to commit themselves to this effort.

B) The following motion was passed by the Planning Council.

To appoint a Long Range Planning Subcommittee that will develop a strategic plan to establish a new model for HIV service delivery.

Planning Council members interested in serving on this subcommittee should contact Mark Morewitz at 554-9028. Sophia Chang will meet with the current subcommittee on March 1, 1993 at 4:30 at the AIDS Office. The next meeting of this subcommittee will be on March 8, 1993 at 2:30 prior to the Planning Council meeting scheduled for the same day.

V. Review of 1992 HOPWA Awards and Prioritization of 1993 HOPWA Funds

Bill Rumpf from the San Francisco Redevelopment Agency presented the progress report on Housing Opportunities for People with AIDS (HOPWA) which is attached. He announced that the application for the next funding cycle is due March 15, 1993.

Mr. Rumpf reiterated that HOPWA funds do not eliminate the need for supportive services/operating expenses; the funds do eliminate the need for leased housing. Supportive services/operating expenses are eligible expenses for both HOPWA and CARE. Mr. Rumpf alerted the Planning Council to the need for ongoing support for HOPWA-funded programs (i.e. that continued funding of supportive services/operating expenses could compete with the need to use HOPWA funds for capital programs.) For the first year, however, he agreed that allocating HOPWA for these expenses made sense because of less pressure to expend these funds.

In reviewing the 1992 funding targets, Bill Rumpf pointed out that Lease/Rental Assistance projections were not met due to the rejection of proposals in this category. Bill Haskell stated that, in the future, the Support Center may be able to provide technical assistance to help potential contractors with proposal writing. Mr. Rumpf announced that the 1993 application would include a request for funds to cover licensure expenses incurred by HOPWA-supported residential programs.

He also stated that the SFRA is committed to a formal needs assessment to identify overall needs and which programs (HOPWA and CARE) should support specific housing needs. Mr. Rumpf acknowledged he has not presented the 1993 funding targets to the HIV/AIDS Housing Network (a Community forum of housing providers).

C. The following motion was passed by the Planning Council. Abstentions: Bob Nelson and Eric Rofes.

To endorse the current percentage breakdown of HOPWA funding targets for the next funding cycle with understanding that the HIV/AIDS Housing Network (a community forum of housing providers) will have input at a later date.

Estela Garcia thanked Mr. Rumpf for his work and presentation. Dr. Hernandez acknowledged the success of the Department of Public Health AIDS Office, the San Francisco Redevelopment Agency, and the Mayor's Office of Housing in working so well together on the first cycle of HOPWA funds.

VI. Public Testimony

Walter Park, Executive Director of Independent Housing Services, presented needed services for inclusion in a comprehensive HIV Housing Resources/Referral Network.

1. General information and referral for clients.
2. Assistance for clients to undertake search for housing (one-to-one personal contact).
3. Housing case management, including in-home visits and direct assistance, is required for many clients.
4. Credit advice for transportation/moving costs.
5. Assistance with discrimination/legal referrals.
6. Housing counseling/Intervention with repeated follow-up and intensive assistance.
7. Assistance needed in applying for subsidized housing.
8. Maintenance database for private housing sources is needed.
9. Training for CBOs in housing counseling to include independent living situations.

Mr. Park pointed out that shared housing will not work for some clients. Shared matches can fall apart; they are hard to sustain. Most clients want a single unit. He also noted that Clients with substance abuse and mental health issues require housing case management (not just counseling).

Tentative Agenda for March 22, 1992

1. Discussion of the City Budget
2. HOPWA NOFA/SFRA
3. CastleRock: Presentation on Copayment System

SF
H22
#1
3/8/93

City and County of San Francisco

Department of Public Health

DOCUMENTS DEPT.
MAR 05 1993
SAN FRANCISCO
PUBLIC LIBRARY

HIV HEALTH SERVICE PLANNING COUNCIL
March 8, 1993
25 Van Ness, Third Floor Conference Room
4:30-7:30 p.m.

AGENDA

I. Roll Call

II. Review of Agenda and Minutes

III. General Announcements

IV. General Business

- Letter of Support for Title III Application
- Authorization for S.F. AIDS Foundation to Provide the Case Management/Advocacy Services Previously Provided by CURAS.

V. Review Decision to Defund the Health Outreach Team

VI. People of Color and HIV

- *Review of Recommendations in People of Color and HIV Report: Planning for Treatment and Services.

- Facilitated Discussion (Deborah Johnson): How to implement the recommendations included in the People of Color and HIV Report.

VII. Public Comment

*Please see enclosed attachment: Fiscal Year 92 CARE Funding for POC by Service Type, for use in discussion.

AIDS OFFICE

25 VAN NESS AVENUE, SUITE 500
SAN FRANCISCO, CA 94102 - 6033

415 - 554-9000
FAX 415 - 431-7547

DOCUMENTS DEPT
MAR 15 1993
SAN FRANCISCO
PUBLIC LIBRARY

HIV HEALTH SERVICES PLANNING COUNCIL

March 8, 1993
4:30 - 7:30 p.m.

Minutes

Members Present: Reggie Williams, Marcy Fraser, Yvonne Frazier, Estela Garcia, Gerald Lenoir, Gifford Leoung, Steve Lew, Kent Macdonald, J.B. Molaghan, Bob Nelson, Steve Rogers,Mike Shriver Laura Thomas, Pat Underwood, Jerry Windley, Mary Jane Wood

Members Absent: Sandra Hernandez, Pat Christen, Jaime Geaga, Les Hanson, Karen Hembry, Scott Miller, Elliot Ramos, Eric Rofes

Staff Present: Sophia Chang, Mitch Katz, James Loyce, Bill Haskell, Valerie Dorr, Tim Offut, Kandyce Pilar Collins, Jon Dean Green

I. Roll Call

Roll Call was taken as above.

II. Review of Agenda and Minutes

The approval of the minutes and agenda was delayed until later in the meeting to allow for more copies to be made.

III. General Announcements

James Loyce, Associate Director for Administration, stated that AIDS Indigent Direct Services (A.I.D.S.) has been placed in "receivership" by the AIDS Office. The AIDS Office received a letter stating that A.I.D.S. had used funds from the client's representative payee program to cover payroll expenses. The money was subsequently replaced into the account for this program. Doug Benbow, the Executive Director of A.I.D.S., stated that the accusation in the letter was true. The AIDS Office has informed the Social Security Administration, District Attorney's Office and the City Attorney about this matter. The District Attorney has requested the AIDS Office's audit of A.I.D.S. when it is completed. The City Attorney has approved the receivership. Tim Offutt, Minority Initiatives Coordinator, has been assigned to A.I.D.S as the acting administrator. All cash, employee time sheets, invoices, deposits, and financial activities must be approved by Tim Offutt. All revenue will be ledgered and placed in the appropriate accounts. Mr. Loyce will meet with the A.I.D.S. Board of Directors on Wednesday, March 10, 1993. He will present the Board with the 30-day notice of termination of contract support for the representative payee program and will investigate other agencies' ability to provide this service. The AIDS Office will assure continuation of services during the transition. The Controller's Office is currently reviewing the audit. Upon completion of the investigation of A.I.D.S., the findings will be brought to the Planning Council. The AIDS Office is recommending discontinuation of contract support for the A.I.D.S. representative payee program.

Q-Will all contracts held by A.I.D.S. be examined? A-Yes.

Mitch Katz, Director, stated the AIDS Office is currently reviewing Shanti Project's contract compliance for FY 1991-92 and 1992-93. The monitoring report was completed and sent to the Shanti Executive Director and Board President on February 23, 1993. The document has been signed and a response submitted to the AIDS Office, thereby making it public. Dr. Katz stated that Shanti received satisfactory scores in all areas excepting financial accounting. This area received an "unacceptable" rating. Shanti billed the AIDS Office for housing that was not in place. Shanti also billed the AIDS Office for line items not contained in its contracts. The boilerplate language of all contracts requires agencies to consult with the AIDS Office for any contract modifications. This was not done in either 1991-92 of 1992-93. Shanti did not report the 25% of client's income it collected as a share of cost in housing services. This revenue collection was not documented as being used to provide additional housing nor reported to the AIDS Office. Shanti did not have the appropriate audit (an OMB-A133) for the size of its governmental contracts. It also lacked the appropriate level of controls for its funds. Shanti has accepted responsibility for its fiscal practices and a plan to rectify the situation has been submitted. Shanti must submit a reconciled budget to the AIDS Office. The allowable costs incurred by Shanti that are documented by receipt will be paid. Shanti will have to return all monies not documented as part of contractual expenses. The AIDS Office has not paid any invoices for January and February of 1993 that are not in line with Shanti's contracts. The AIDS Office hopes to complete contract modifications for current contracts to bring them into conformation with allowable expenditures.

Q-Is there a mechanism within the AIDS Office accounting procedures to do year-end reconciliation? A-Historically, the AIDS Office has required audits within 90 days of a contract's closure to review expenses incurred in relation to contractual line items. Shanti must perform an OMB A-133 audit, perform a budget reconciliation and return any monies not expended for appropriate housing programs.

J.B. Molaghan expressed concern that the allegations regarding both A.I.D.S. and Shanti came from former employees and were not picked up the routine monitoring process. Mr. Loyce responded that AIDS Office staff are trained in review of appropriate fiscal procedures. They are not trained auditors.

Bob Nelson stated that there needs to be a place to refer clients for representative payee services. A provider for these services is desperately needed.

A) The following motion was passed by the Planning Council:

> To defer discussion of the People of Color and HIV Report to March 29, 1993, and add Shanti Project and A.I.D.S. to the agenda.

Pat Underwood stated that if A.I.D.S is breaking the law with one contract, the Planning Council should not allow it to retain any CARE contracts. This is a very serious issue. Mitch Katz stated that the AIDS Office is currently checking to see if the Board knew of the actions taken by the Executive Director. Ms. Underwood stated that, at a minimum, the AIDS Office must assure that the Executive Director is terminated. It is completely unethical to take client's money to cover payroll expenses. Marcy Fraser stated that even if the Board did not know about the transfer of funds from the representative payee program, its lack of knowledge that the agency did not have funds to make payroll is seriously problematic.

B) The following motion was passed by the Planning Council:

To accept the AIDS Office recommendation of placing A.I.D.S. in receivership.

The following motion was proposed:

To cancel all CARE contracts with A.I.D.S. in a timely manner so as to be assured clients are served.

Gerald Lenoir stated that he opposed the motion because he believed the Planning Council must act responsibly about the delivery of services. He stated that the responsible thing to do is have the Executive Director removed. Mr. Lenoir was not ready to have all contracts terminated. Marcy Fraser stated that she supported the motion. Ms. Fraser stated her concern that the Planning Council might continue services at A.I.D.S. because it happens to be in place, rather than because it provides the best services. Kent Macdonald stated he opposed the motion. He felt that terminating all CARE contracts with A.I.D.S. would be a precipitous act. If the Planning Council is that severe with A.I.D.S. it must hold Shanti to the same standard. Mr. Macdonald stated that in both cases someone knew that funds were being co-mingled and that poor accounting practices were in place. Jerry Windley stated the he supported the motion. The Board of Directors of A.I.D.S. is legally responsible for the actions of its employees. Agencies that are misappropriating funds must be punished. Other agencies can be developed to take on the current contracts held by A.I.D.S. Michael Shriver stated that A.I.D.S. broke the law. The matter must be dealt with immediately. Pat Underwood reiterated that the question was not one of service delivery. The matter at hand directly relates to legal-ethical behavior. The Planning Council has oversight, responsibility and accountability for the monies it disburses. The Planning Council must maintain and uphold is own fiduciary responsibilities. This is also a matter of the fiduciary responsibility of A.I.D.S.

The above motion failed to pass the Planning Council.

In the interests of time, before retaking up Shanti and A.I.D.S, the Planning Council asked for General Announcements and moved to General Business.

Michael Shriver stated that President Clinton is proposing an augmentation of $200 million in CARE funds in the supplemental budget the President is submitting to Congress. Of the $200 million, $85 million would go to CARE Titles I & II respectively, $25 million to CARE Title IIIb and $5 million of the pediatric component of CARE Title IV. Secretary Shalala has stated that the $200 million augmentation should be considered as part of the baseline for next year's CARE allocation. Mr. Shriver stated that the supplemental monies will probably be allocated in a formulaic manner if the funds are approved by Congress. San Francisco would then receive ~$6 million new dollars. There is still a question of whether these additional funds would become part of San Francisco's baseline and could be rolled over into Y04.

Steve Lew stated that he attended a meeting in Alexandria, Virginia, devoted to developing a nationwide AIDS agenda. The five areas considered were Prevention, Care, Research, Discrimination, and the need for national Leadership. Mr. Lew and Yvette Flunder were two representatives from the Bay Area.

Jerry Windley stated that the minutes from the previous week were mistaken on the date of the Health and Public Safety Meeting of the Board of Supervisors. The actual date is Tuesday, March 23, 1993. The meeting will be at 10:00 a.m. in Room 228 of City Hall. For further information, he can be contacted at Supervisor Alioto's Office in the afternoons at 554-7788.

Bob Nelson announced that Bill Rumpf had met with the HIV Housing Network. The group will be working with the Redevelopment Agency on a needs assessment and long range plan for housing.

C) The following motion was passed by the Planning Council:

> To approve the minutes of the February 22, 1993 meeting with the corrected dated of the Health and Public Safety meeting.

Estela Garcia announced that the Subcommittee of the Planning Council had met to examine the decision to defund the Health Outreach Team (HOT). The team consisted of Gifford Leoung, Kent Macdonald, Jerry Windley and Estela Garcia. Ms. Garcia complimented the AIDS Office for providing a chronological outline of events, copies of all correspondence and other information for the Subcommittee to maundertake its examination. The Subcommittee met on 2/26/93 and 3/5/93. The Subcommittee recommended that the Planning Council rescind its decision to defund HOT. The Subcommittee felt that HOT had made good faith efforts to comply with the interventions identified in the monitoring report. Ms. Garcia stated that the Subcommittee weighed very heavily client testimony regarding the unique services HOT provides. Gifford Leoung stated that the Subcommittee did not disagree with the original review team's recommendations. However, HOT has made marked efforts to improve its administrative structure. Jerry Windley stated that he was impressed with the amount of client support for the agency. Clients did not want to have to seek services at Tom Waddell Clinic.

D) The following motion was passed by the Planning Council, with Mary Jane Wood and Yvonne Frazier abstaining.:

> The decision to defund HOT be rescinded, and that HOT be funded for FY 1993-94 provisional on continued improvements identified in the monitoring report.

IV. General Business

Valerie Dorr requested a letter of support for the CARE Title IIIb application. She stated that for the past two years the Department of Public Health has applied to the Centers for Disease Control for Title IIIb monies to fund an Early Intervention Network. This grant is different from the monies currently received by the San Francisco Community Clinic Consortium. The proposed service is a central appointment system linking the Health Centers along with a promotional campaign for early intervention. There will also be a targeted outreach to African Americans in the Bayview and OMI neighborhoods.

E) The following motion was passed by the Planning Council, with Michael Shriver abstaining:

> To provide a letter of support to the DPH Title IIIb Application.

Mitch Katz stated that the case management program at CURAS had been terminated with the clients transferred to the San Francisco AIDS Foundation. The AIDS Office worked with the community to transfer the clients. The AIDS Office met with the CURAS Board of Directors, the CURAS Rescue Committee, clients, as well as other Latino service providers to discuss where to best place the services. The group agreed to transition both the services and the CURAS case managers to the Multicultural Program at the AIDS Foundation. Estela Garcia spent time examining client charts and worked on the transition. CURAS clients were informed that they could seek services wherever they liked and that the former CURAS program had been relocated to the AIDS Foundation. The contract will remain with the AIDS Foundation for the next 18 months before being put out to competitive bid. This is being done to minimize client confusion over services and client drop-out. The extended time before rebidding of the service was decided by the group before a service site was chosen. Estela Garcia stated that a letter had been sent by Concha Sauseda to the Planning Council concerning Instituto's perspective on the transition of the contract. Her concern was that it had not been passed on to the Planning Council.

Q-Is the contract already in place with the provider, without Planning Council approval? A-No. The contract is in negotiation. It has not been signed. Sophia Chang apologized to the Planning Council for not presenting this information sooner.

F) The following motion was passed by the Planning Council, with Estela Garcia, Steve Lew and Bob Nelson abstaining:

> To accept the AIDS Office recommendation to award the previous CURAS case management contracts to the San Francisco AIDS Foundation.

Continued Discussion of A.I.D.S. and Shanti

Gerald Lenoir asked Jimmy Loyce when the full findings on A.I.D.S. would be available. Mr. Loyce stated that his portion would be done in two to three weeks. The Controller's Office has just received the independent audit. He does not know if the Controller's Office will want to perform its own examination.

Pat Underwood stated that CURAS had been defunded for fiscal improprieties and bad management. From her perspective there is an issue concerning the Planning Council's ability to assure appropriate management of the funds overwhich it has oversight. Laura Thomas asked what could be done to assure the Planning Council receives the fiscal expertise it needs? Sophia Chang replied that Sandra Hernandez is looking at the CARE administrative budget to develop an audit unit within the AIDS Office to review accounting records. Yvonne Frazier stated that a system to resolve problems and/or defunding of programs could be set up that has various steps. The first step would be an agency receives a warning and notification of necessary changes and is placed on probation. Dependent upon the agency meeting the requirements to get off of probation, the Planning Council would then either move to further action such as delays in payment or defunding, or removing the agency from probation. There could also be circumstances under which the warning/probation phase would be bypassed. In this instance, the Planning Council would move immediately to defunding a program.

Q-Why had Shanti's fiscal problems not been caught in its audit? A-Shanti submitted its audit late. Monitoring reports submitted by Shanti indicated that it had the ability to allocate monies to the appropriate contracts.

Marcy Fraser stated that there is a grey zone between breaking the rules and breaking the law. A.I.D.S. clearly passed over that line into illegalities. Jerry Windley stated that probation is fine for programmatic problems. The issue with A.I.D.S. is a matter of theft, money was stolen.

Q-Do all AIDS Office contracts specify fund accounting? A-Yes. It is in the boilerplate language for all contracts.

Michael Shriver stated that there is a clear violation of the law with A.I.D.S. He stated that in the case of Shanti, billing for services not rendered is fraudulent. Mitch Katz stated that 1/12 billing is problematic. In previous years the AIDS Office allowed this practice, but required agencies to have documentable expenditures. Shanti has not accounted for client revenues. The monies may have gone to provide other services.

Q-If the Planning Council decision is to remove all CARE contracts with A.I.D.S., will the AIDS Office be able to find other agencies to provide the services in a timely manner? It would be unfair to punish the clients; this must be balanced with the need to let the agency know the seriousness of the situation.

Sophia Chang stated that the Planning Council's mission is to assure the provision of HIV services to persons with HIV in the community. The Planning Council entrusted an agency to take care of clients' money. These funds were the clients' lifeline and the only way for clients to pay for food and shelter.

J.B. Molaghan stated that if a nurse is caught stealing drugs he or she is fired, not reinforced in such behavior. The Planning Council removed all CARE monies from CURAS and found another provider. The issue at hand with A.I.D.S. is a legal problem. It is a disservice to the clients to look away from the problem. A.I.D.S. must have all of its CARE funding removed. This is a very serious issue.

Laura Thomas stated that all CARE funds should be removed form A.I.D.S. The Shanti matter is also very serious. If A.I.D.S. is salvageable, it can come before the Planning Council, present a plan of action and request the Planning Council to reconsider the issue. The representative payee issue is not only a legal problem, it is a matter of ethics. As for Shanti, the agency should have known better. The agency is large and should be able to better handle the public monies with which it is entrusted.

Kent Macdonald asked who at A.I.D.S. is culpable. The Planning Council is generalizing that A.I.D.S. as a whole is culpable, when in fact in may only be an individual--the Executive Director. Mr. Macdonald reiterated that the issue was a serious breach of trust. The message sent by the Planning Council must be studied and appropriate. The Planning Council must not overreact.

The following motion was proposed:

That a letter be sent to the A.I.D.S. Board of Directors stating the Planning Council is outraged and dismayed by events at the agency. If appropriate actions are not taken by the Board, the Planning Council will consider defunding the agency and terminating all CARE contracts.

Bob Nelson spoke against the motion. The agency stole clients' money. These clients are people who have been abused by society. This agency has betrayed clients and their trust. It makes no sense to continue to fund housing case management and send agency representatives into clients' homes when they have stolen funds from these clients.

Gifford Leoung stated that the Shanti issue needs further clarification. A.I.D.S. is different. The principles involved have admitted to fiscal irregularities. The price of receiving CARE funds is following the rules. A.I.D.S. broke both the rules and the law. Dr. Leoung asked what could be said by A.I.D.S. that would make a difference concerning the theft of clients' money? Jerry Windley stated that the actions of Shanti and A.I.D.S. perpetuates the image that agencies don't care about their clients, andt are in the business of making money off of clients who are dying. The Planning Council must take a strong stand. Clients are losing faith and trust in the agencies that are supposed to be taking care of them. This situation sets a bad precedent for the very persons the Planning Council is supposed to represent. J.B. Molaghan stated that clients' trust in A.I.D.S. is poisoned. Its credibility is now lacking. The Planning Council must not be guilty of collusion by taking no action. If an Executive Director performs these actions, they act on behalf of an agency. The Planning Council must move to assure services are provided at a reputable agency. Gerald Lenoir stated that there must be no tinge of a double standard between the actions taken by the Planning Council on A.I.D.S. and those to be taken concerning Shanti. This is very important in terms of the community's perception of impartiality.

Michael Shriver stated that the impact of the media cannot be discounted. Mismanaged Ryan White CARE monies are mismanaged Ryan White CARE monies. There are repercussions to this in Washington that could effect San Francisco's ability to compete for funds in the coming year. Yvonne Frazier stated she was in favor of defunding A.I.D.S. The agency had admitted its guilt. Mary Jane Wood stated that her concern was if A.I.D.S. had not been caught, it would have happened again. The Board should have known it did not have the money to make payroll. The Board is legally responsible for the actions of its employees and oversight of all funds. Michael Shriver stated that the Shanti matter must be continued to the meeting of March 22, 1993, with the same level of discussion. The AIDS Office should seek legal counsel on whether fraud was committed.

The above motion failed to pass the Planning Council.

G) The following motion was passed by the Planning Council, with Bob Nelson abstaining:

> To cancel all CARE contracts with A.I.D.S. in a timely manner so as to be assured clients are served. The priority is continued services to clients in as appropriate and expeditious manner as possible.

Public Comment

Alicia Lara, Shanti Project, stated Shanti had a system that internally allocated monies by department. Six months ago Shanti had a discussion with the AIDS Office regarding its lack of compliance in fiscal practices. There has been no determination of legal failure on Shanti's part. There will be marked changes in Shanti's fiscal practices by year end.

03103gca

HIV HEALTH SERVICES PLANNING COUNCIL

March 22, 1993

The Agenda of this meeting is missing.

San Francisco Public Library
Government Information Center

SF
H22
#2
3/22/93

HIV HEALTH SERVICES PLANNING COUNCIL

March 22, 1993
4:30 - 8:30 p.m.

minute

Members Present:	Sandra Hernandez, Pat Christen, Marcy Fraser, Yvonne Frazier, Estela Garcia, Jaime Geaga, Les Hanson, Gerald Lenoir, Gifford Leoung, Steve Lew, Kent Macdonald, Scott Miller, J.B. Molaghan, Bob Nelson, Elliot Ramos, Steve Roger, Mike Shriver, Laura Thomas, Patricia Underwood, Jerry Windley, Mary Jane Wood
Members Absent:	Reggie Williams, Karen Hembry, Eric Rofes
Staff Present:	Sophia Chang, Mitch Katz, James Loyce, Bill Haskell, Galen Leung, Kandyce Pilar Collins, Tim Offutt, Jon Dean Green

I. Roll Call

DOCUMENTS DEPT.
APR - 1 1993
SAN FRANCISCO
PUBLIC LIBRARY

Roll Call was taken as above.

II. Review of Agenda and Minutes

The minutes of the March 8, 1993, meeting and the March 22, 1993, agenda were approved.

III. Mayor Jordan

Mayor Jordan announced that he had just completed signing the Board of Supervisors proposed needle exchange legislation. Mayor Jordan thanked everyone for their efforts and congratulated Prevention Point on the courageous work it had accomplished. Mayor Jordan stated that Speaker Willie Brown is introducing Assembly Bill 260 to pursue needle exchange on a state level. The Mayor next announced that he has appointed three new members to the Planning Council: Susan Karp, Rita Times (spelling?) and Barbara Garcia.

Mayor Jordan stated that, since his last appearance at a Planning Council meeting, he has been to Washington, D.C. on two occasions and followed up on CARE funding. He stated that domestic issues are the uppermost concerns of the Clinton administration. The Mayor is hopeful that cities will receive an infusion of new monies to provide health and human services, create jobs and proceed with urban reconstruction.

Mayor Jordan stated that the City budget deficit is projected to be $184 million. He must present a balanced budget to the Board of Supervisors by June 1, 1993. The Board of Supervisors has until July 1, 1993, to make changes. At two neighborhood meetings Mayor Jordan has held, he gave perspective to the magnitude of the problem by stating that to balance the $184 million deficit, the City would have to cut 2,500 positions to reach $92 million in savings, cut $46 million in services, and raise $46 million in revenue generation (e.g., taxes, increased fees). The Mayor stated that he has received a number of different suggestions for revenue generation and streamlining of City services. He is currently looking for solutions to the immediate problem of needing a balanced budget by June 1, 1993, and of placing measures on the November ballot for more long term resolution. Mayor Jordan stated that individuals

may send him feedback and information on cost efficiencies, revenue generation and essential services that must be maintained.

Q-Where do health services fit in your list of priorities? A-It is in the top three or four priorities. With 30% of the population uninsured, the City must be able to care for the ill and injured. The Mayor stated he has no intention of cutting AIDS service dollars. He is interested in looking to streamlining of the health care system for cost savings.

The Mayor stated that 61% of the public are concerned with the homeless. The City spends $50 million a year on the homeless, with another $40 million going to General Assistance. The City must examine service provision to this population. There are estimates of 6,000 people on the street: 1/3 are out of work, 1/3 have mental health issues, and 1/3 substance abuse issues. The question that needs to be considered is whether the $90 million is being spent in the best way possible, and how to make the money go further.

Q-There have been concerns expressed that the two current health commissioners have conflict of interest on AIDS due to where they work. Will the Mayor appoint someone to replace Pierre Ludington who is able to actually speak and vote on issues that concern HIV disease? A-Keith Martin and Melinda Paras are very knowledgeable in their respective areas. The Mayor stated they bring a great deal of expertise on AIDS to the Health Commission. Sandra Hernandez stated that the City Attorney's Office is present at the Health Commission meetings. The Health Commissioners are advised on conflict of interest. Part of the concern that Planning Council members have is that during approval of CARE contracts, three Health Commissioners were unable to vote due to their respective ties to Shanti, CPMC, and the Support Center.

Q-How is the Mayor looking to diversify the Board of Supervisors? Will a Latino(a) be appointed to the Board? A-The Mayor stated that Roberta Achtenberg is not gone yet. He is under intense pressure and lobbying over the seat. African Americans want Doris Ward's place taken by an African American. The Mayor is taking everything under advisement, and the appointment will be based on what is best for the City.

Estela Garcia stated that the Planning Council has taken the issue of long range planning under advisement. Ms. Garcia asked the Mayor to examine the recommendations from the Planning Council on long range planning. There are serious challenges concerning resource allocation. The City must move back from conducting business on a day-to-day manner. There must be a vision of what services will look like. The Planning Council has oversight of a large amount of funds. Ms. Garcia stated that the Planning Council would like to see a concerted effort to provide efficient and effective services. Sandra Hernandez stated that the Planning Council is assessing the health care system and looking at collaboration and consolidation. The San Francisco model for the continuum of care continues to evolve and develop. The Planning Council is looking to create greater efficiency. The Planning Council wants to work with the Mayor to meet the needs of persons with HIV disease within the constraints of the budget.

The Mayor stated that he will need the support and help of members of the Planning Council and their constituencies to meet the challenges facing the City. San Francisco must look to new, creative, and innovative means to address HIV. The Mayor wants San Francisco to be the unquestioned leader on state-of-the art provision of HIV care.

IV. General Announcements

There were no general announcements.

V. Update on the Copayment Consultant

The update was deferred to the April 12, 1993 meeting.

VI. Update on HOPWA Notice of Fund Availability for Year 02

The update was deferred to the April 12, 1993 meeting.

VII. Discussion and Update of Shanti Project and AIDS Indigent Direct Services Reports

Due to the large number of persons present to make public comment on Shanti and AIDS Indigent Direct Services (A.I.D.S.), public comment was taken first.

Al Cunningham: Mr. Cunningham stated he is a former board member and former executive director of A.I.D.S. Mr. Cunningham stated that A.I.D.S. performs an excellent service for indigent persons needing treatment with dignity and concern. During his tenure he attempted to put in place appropriate fiscal mechanisms and sought technical assistance from the Support Center. The Support Center did not provide him with appropriate or useful technical assistance. Mr. Cunningham stated that the Examiner articles on A.I.D.S. demonstrated reckless journalism. Ms. Krieger's article was based on the reports of a single individual. Ms Krieger had minimal board of director input. Mr. Cunningham stated that the staff is loyal to the 300 clients it serves. The staff worries that the clients will fall through the cracks if A.I.D.S. is defunded. The clients' lives hang in the balance. Mr. Cunningham had three requests of the Planning Council: 1) protest of the biased Examiner reporting (Shanti was not criticized in the same manner as A.I.D.S.); 2) rescind the defunding decision; and 3) ensure efficient technical assistance that is appropriate and culturally competent.

Q-The Support Center was not helpful? A-No. The staff did not seem well informed. Also, the timeline for assistance was too long.

Q-Was the AIDS Office informed of the problems with the technical assistance? A-No.

Audrey Doughty: (Refer to enclosed handout.)

Cheryl Hulitt: Ms. Hulitt stated she had been a client of A.I.D.S. since December. She receives breakfast, comfort and support. The agency does a lot for her, and she has gained 25 pounds. Ms. Hulitt is encouraged by the staff. She receives both health care and heart care.

Robert Morgan: Mr. Morgan has been a client at A.I.D.S. for eight months. The emotional support he receives is as important as the services. June helped him stabilize his living situation. The program needs to continue in the Tenderloin.

Dorian Kreis: Mr. Kreis has nothing but praise for A.I.D.S. The staff have given him psychological support and services and a support network. Please don't cut the program.

Donald Smith: Mr. Smith stated he needs this program.

Todd Jamison: Mr. Jamison asked the Planning Council to not hold clients accountable for the mistakes made by staff.

Steve Moore: Mr. Moore has been a client since January. The program has helped him with health care. Please don't cut them.

Bruce Occenia: Mr. Occenia lives and works in the Tenderloin. A.I.D.S. has the most organic way of meeting the needs of Tenderloin clients. A.I.D.S has both courage and heart. The agency has grown quickly. It needs to be allowed time to address the administrative difficulties it is experiencing. Who will provide the services if A.I.D.S. doesn't? Mr. Occenia asked the Planning Council not to act in a punitive manner.

Andrew Farley: Mr. Farley stated he is a long term survivor. He has been diagnosed with AIDS since 1986. The staff at A.I.D.S. are caring. Terminally ill clients need services. Mr. Farley is currently in recovery because of the services provided by A.I.D.S. at the Ambassador. He now channels his energy and anger correctly to fight his disease and for things such as A.I.D.S. survival.

Ariel Rachels: Mr. Rachels stated that A.I.D.S. has given him a new chance. He has been clean and sober for 49 days. He could not have entered substance abuse treatment without A.I.D.S., and otherwise he would be dead or very high. Give the agency a chance.

Ellen Hardtke: Ms. Hardtke stated she is a whistle blower and proud of it. She reported the mismanagement at Shanti because of her concern for the clients. Ms. Hardtke is upset because of the clients who died without a home due to Shanti's problems. CURAS and A.I.D.S. have been held to a different standard than Shanti. It is inappropriate that People of Color agencies should be treated by a different standard.

Valentine Aguirre: Mr. Aguirre stated that there are many commitments that come with an attempt to provide services. There are inadequate mechanisms in place by the Planning Council to examine fiscal practices. Mr. Aguirre is disturbed by some of the comments made in the prior minutes. There seems to be a dichotomy between the treatment of A.I.D.S. and Shanti. He wants the Planning Council to have a strong commitment to technical assistance and appropriate fiscal practices.

Joy Rucker: Ms. Rucker is the program director at Rafiki House. A.I.D.S. provides services that no one else is able or willing to. It is a hard population to serve. Its clients are homeless and substance using. The financial problems need to be addressed. Pulling the agency's funds will only hurt the clients. Who else will provide these services to clients in the Tenderloin?

Tom Calvanese: Mr. Calvanese is a manager at the Ambassador Hotel. The problem he sees is in the Planning Council process for defunding agencies. The Planning Council is addressing this issue with its proposed changes in the process. A.I.D.S. has administrative problems. Technical assistance can help with this. The AIDS Office and Planning Council must work with contractors to aid them. Mr. Calvanese wants A.I.D.S. to have a chance.

Hank Wilson: A.I.D.S. services are better than they have ever been. Clients continue to receive services. The board of directors has new members. A.I.D.S. services are not dependent on one person.

Don't punish the clients for the former executive director's mistakes. A.I.D.S. doesn't just tell clients how to access services, it walks and talks them through the process. A.I.D.S. has problems, but it can survive them with help.

Fred Noble: Mr. Noble stated that A.I.D.S. has a serious credibility problem with its board of directors. Over a year ago Ms. Doughty stated that A.I.D.S. would fund raise to meet the 70% rule for CARE monies. The money has not been raised. The agency should be held to the 70% rule. There is a need for services in the Tenderloin. There are conflicts with lovers of board members serving as staff. If the Planning Council wishes to continue services, it should remove the board of directors and have overall change.

Michael Mabe: Mr. Mabe is a homeless person. A.I.D.S. has helped him by giving him the strength to face his disease. The clients are telling of their needs and the Planning Council needs to both listen and hear. Clients are saying give A.I.D.S. a chance.

Michael Freeman McGuire: Mr. Freeman McGuire is the founding director of A.I.D.S. He is profoundly disturbed that the dream that started on April 1, 1989 could end. Mr. Freeman McGuire is proud of the agency and its clients. There was work that needed to be done in the Tenderloin, and with the help of the Ambassador hotel, the agency opened its doors. A.I.D.S. grew overnight with the advent of CARE monies. Mr. Freeman McGuire stated he was present to plead with the Planning Council to keep the agency intact.

June Cummings: Ms. Cummings stated she is the "un-degreed" social worker referred to previously. Ms. Cummings stated that while she did not have a degree, she learned her skills on the street. A.I.D.S. is a prototype. There are peoples living in Tenderloins in other places--Richmond, Oakland, Chicago. Don't strike the agency down. It needs help. With help it could be a model for service provision. The clients mean a lot to Ms. Cummings.

Duane Brown: Mr. Brown has had experience with both Shanti and A.I.D.S. Mr. Brown stated that Ryan White must be rolling over in his grave to see what Shanti has done in his name. Every year there are problems with Shanti. If funds are removed from A.I.D.S., remove them from Shanti. Shanti is an elitist organization. It is easier to reach Nancy Pelosi than to speak with Eric Rofes. If something is to be done, the treatment must be equitable and fair for all agencies.

Kerrington Osborne: Mr. Osborne felt the A.I.D.S. defunding was capricious. The decision seemed unfair to the clients. Clients are disenfranchised and many are substance using. Don't hold the clients responsible, hold the board and staff responsible. Seek additional funding from HRSA to provide technical assistance and administrative help for community-based organizations.

Eric Jones: Mr. Jones stated that A.I.D.S. has helped him receive SSI. It has also given him support and counseling. Mr. Jones has attempted suicide on several occasions and A.I.D.S. has seen him through the bad times.

Mr. Salinas: Mr. Salinas stated he is a client of A.I.D.S. and has been clean and sober for seven days. A.I.D.S. is a tremendous help. He would like to see Planning Council members come live in the Tenderloin for thirty days.

Val Robb: Ms. Robb is a VN&H nurse. She has worked in the Ambassador for three years. Ms. Robb would be unable to do the work currently being done without A.I.D.S. Ms. Robb has the utmost respect for the agency and its staff.

Rufus Harris: Mr. Harris has been a client of A.I.D.S. since February, 1990. A.I.D.S. provides great service. He attempted to access service at Shanti in the past and after two years was told his name was not even on the waiting list. There is a need for people of color services that are appropriate. A.I.D.S. provides service and a loving smile. Without A.I.D.S. people will die on the streets.

Henry Mally: (Refer to enclosed handout.)

Q-What is your recommendation to the Planning Council? A-Dr. Mally hopes the Planning Council will rescind its defunding decision subsequent to completion of the AIDS Office investigation and issuance of the report so that the agency has a chance to respond. Dr. Mally wants the agency to survive. He stated he would gladly step down from the board if necessary.

Erica Huggins: Ms. Huggins stated she was raised in a different generation of activism. There is an enemy in the room. The enemy is people turning on each other. Ms. Huggins stated that everyone in the room had suffered from heinous oppression. She knows the work A.I.D.S. performs. People and personalities are not the issue at hand. Don't turn on each other during a time of crisis. Figure out how to uplift one another. Look to the light that is the vision that started programs such as A.I.D.S. and Crossings.

Sandra Hernandez thanked the people present for coming and presenting public testimony.

Jimmy Loyce, AIDS Office, presented an update on A.I.D.S. Mr. Loyce stated the AIDS Office is completing its administrative and programmatic audit. The primary issue continues to be the financial management. The Controller's Office must still come to a decision. It can either accept the AIDS Office report and not perform its own fiscal audit, or it can perform a fiscal audit. If the Controller's Office performs an audit, it will take two to three weeks to accomplish the work and two to three weeks to complete its report.

Q-If the Controller's Office does not perform an audit, can the AIDS Office get an auditor to examine A.I.D.S. records? A-The AIDS Office could request A.I.D.S. to obtain an audit similar to an OMB A-133 audit. This would take one to three months. The hope of the AIDS Office is to have the Controller perform the audit.

Q-Comingling of funds is a concern. Is it true that the Social Security Administration does not have a requirement for separate accounts? A-Separate accounts is not necessarily a requirement. There is, however, a specific access point required. If money is taken and put into an account not marked for the beneficiaries' use, this is a violation of the law.

Q-Has the City Attorney been briefed on all issues regarding A.I.D.S. and other agencies that are currently problematic? A-Yes. The City Attorney has been contacted.

Q-Is A.I.D.S. meeting the 70% rule? A-Not at the present time.

Q-What is meant by "receivership"? A-AIDS Office staff is present at A.I.D.S. both in the morning and the afternoon. Revenues and expenditures must be approved. Invoices to the AIDS Office must be initialed.

Q-Who are the current signatories for checks? A-Henry Mally, Monique Davis and Michael Freeman McGuire.

Q-Was A.I.D.S. informed of the receivership? A-Yes. Mr. Loyce spoke with the board of directors and Ms. Doughty before the Examiner article was printed. On March 8, 1993, was when he informed them of the actions he intended to take.

Q-How has the Planning Council's decision to defund A.I.D.S. impacted the process? A-The AIDS Office has not yet sent a 30-day notice of termination of the contract as there is no transition plan for the clients. The AIDS Office recommended termination of the representative payee program, not the termination of all contracts.

A) The following motion was proposed:

> Except for the representative payee program, to rescind the prior Planning Council decision to defund all A.I.D.S. contracts pending completion of the AIDS Office investigation and the Planning Council adoption of a revised defunding process.

Gerald Lenoir stated that the Planning Council badly mishandled the A.I.D.S. situation. The Planning Council responded to pressure from the media. There is a question of process. There was no notification to A.I.D.S. The Planning Council must hold to its responsibility to the community to act appropriately. Mr. Lenoir feels that there has been a serious dichotomy between the treatment of Shanti and A.I.D.S. His concern is the insensitivity shown to agencies serving communities of color.

Laura Thomas stated that the Planning Council did not make a decision based on the media, but on its concern for clients at A.I.D.S. The question raised did not concern the quality of services at A.I.D.S., but rather concerned unethical behavior. The Planning Council wanted to look to other agencies to provide services without questions of illegal actions. The Planning Council is in a position of public trust and must take into account public perception. Clients are the priority of the Planning Council. Clients were not well served by the actions of A.I.D.S.

Pat Underwood stated that the Planning Council has a fiduciary responsibility to the public. The Planning Council must be concerned about fiscal accountability. Without proper oversight, CARE monies will cease to flow, and without funds, clients cannot be served. Ms. Underwood stands by the earlier decision of the Planning Council; she does not feel it was hysterical or precipitous. The Planning Council reacted appropriately to unethical and illegal behavior.

Pat Christen stated she was in favor of the motion. The Planning Council must keep in mind the public trust and client needs. The clients have spoken to their need for the services provided. The AIDS Office has moved prudently with the receivership. The Planning Council now knows where the monies are going until the completed report is issued. The board of directors and senior management of A.I.D.S. must be educated on their fiduciary responsibilities (legal and ethical). Until the completed report is presented to the Planning Council, it is premature to remove all contracts.

Gifford Leoung stated that the decision regarding A.I.D.S was not a rash one. There is a difference between the reported problems of Shanti and A.I.D.S. There is a difference between flawed accounting and taking money that is not yours. The use of the money was illegal. There are certain points that the Planning Council can work with and certain points beyond which the Planning Council cannot go. The vote has not adversely affected the agency, as a 30 day notice of termination has not been sent. The vote should stand until the process is complete.

Estela Garcia stated,however, that the decision by the Planning Council has a negative impact on staff and clients sense of stability. The Planning Council acted conscientiously, but not wisely. The AIDS Office should continue with its process.

Jaime Geaga stated that a different standard seems to be applied to community of color agencies.

J.B. Molaghan stated that the Planning Council must look to the needs of the community impacted by its decisions. Clients have testified that they are receiving good services. The fiduciary responsibility lies with the board of directors. Clients should not be penalized.

Marcy Fraser stated that her concern at the last meeting was that the agency had lost its credibility with the clients. She has learned tonight that clients have received quality services and have continued in their trust of A.I.D.S. The ability of the Planning Council to help agencies develop themselves is lacking. The Planning Council does not have the money to fund help with growth. The Mayor earlier mentioned streamlining of management. Management can not continue to be cut if the City is to have good services. Ms. Fraser stated she was very moved by the clients' testimony.

> The Planning Council approved the above motion, with Bob Nelson and Pat Underwood abstaining.

A further report will be presented by the AIDS Office on its findings concerning A.I.D.S at the meeting of April 12, 1993.

Mitch Katz, AIDS Office, presented an update on Shanti. Dr. Katz stated that the AIDS Office has completed its administrative and programmatic audit. The findings were: Shanti did not track expenses by contract and billed for services that were not delivered; Shanti did not report to the AIDS Office client revenues from its housing programs; Shanti had an inappropriate audit and inadequate accounting procedures. The programmatic rating was satisfactory. Recommendations from the AIDS Office include a reconciliation of the 1991 housing contracts. To do this Shanti must manually track receipts and allocate them to the appropriate contract. Shanti will be required to have an OMB A-133 audit for FY 1991-92 and FY 1992-93. Shanti will have to reconstruct all budgets for these years. The difference between the contractally approved line items and expenses must be returned to the AIDS Office. Shanti must have budget modifications performed for its current 1992-93contracts. The first half of the year must be reconciled and the second half of the year must match contractual line items. The AIDS Office will pay no invoices for January or February of 1993 until this is completed. Shanti has demonstrated to the AIDS Office its current ability to correctly track contracts. Jimmy Loyce and Mitch Katz met with the Shanti finance committee to review the report.

Dr. Katz stated that during the course of the investigation of Shanti by the AIDS Office, two additional inconsistencies have become apparent. The first is that the 1991-92 audit report is inconsistent with the information given to the AIDS Office by Shanti. The audit report shows contracts being tracked by line

item. Shanti states it did not have this ability at that time. Shanti will have an entirely new audit performed. The AIDS Office will work with the first auditor to review the working papers and establish how the auditors determined expenses by contract. The second inconsistency is that the 1991-92 monitoring reports includes information provided by Shanti that the agency had the ability to track expenses by department. The information at this level is currently unavailable. Shanti is reconciling this discrepancy.

Q-What is the AIDS Office recommendation to the Planning Council? A-Shanti's contracts should move forward with an end date of October 1, 1993, for extension of current contracts. Shanti will be given until October 1, 1993 to fulfill the requirements placed upon it by the AIDS Office. Shanti must reconcile the prior year's contracts. Funding past October 1, 1993 is dependent upon Shanti satisfactorily meeting the above requirements.

Q-Does this affect all of Shanti's contracts? A-Yes. General Fund and CARE must be reconciled.

Q-What does it mean that the 1991-92 audit was "inconsistent"? A-The audit showed individual line items being tracked by contract, whereas Shanti did not have this ability. The AIDS Office received the audit on February 24, 1993.

Q-What is the explanation for this inconsistency? A-Dr. Katz stated he had no answer.

Q-Shanti stated it had the ability to track finances by department? A-Yes. Shanti is unable to show records of its ability to do so by department.

Q-Have any laws been broken? A-The AIDS Office has briefed the City Attorney's Office. The City Attorney has not advised the AIDS Office that laws have been broken. The investigation is ongoing. The AIDS Office is unable to explain the inconsistency.

Dr. Katz stated that the October 1, 1993 extension date is necessary. The entire CARE Supplemental budget must be presented to the Health Commission. Until the investigation of Shanti is complete, the AIDS Office is unwilling to renew Shanti's contracts, only extend them.

Michael Shriver stated that he had asked the AIDS Office for a legal finding in regard to Shanti. Mr. Shriver wants a city attorney determination of legality of the actions undertaken by Shanti. Dr. Katz responded that, subsequent to the completion of the investigation, this will be done.

Pat Christen stated that some of the inconsistencies are potentially resolvable and fine, or are not resolvable and very serious. This problem speaks to the issue of boards of directors and senior management needing to understand their fiduciary and accounting responsibilities. Before the October 1, 1993 deadline, the AIDS Office must have a full report for the Planning Council on actions to be taken. Pat Underwood stated that if laws have been broken, then the information must come before the Planning Council for discussion. Action must be similar in nature with what occurred with A.I.D.S.' representative payee program.

Q-Are Ellen Hardtke's allegations being investigated? A-Ms. Hardtke's allegations are documented in the report. During the time in question, Shanti charged the AIDS Office for expenses not incurred. The monies went to other services. The AIDS Office belief is that these other services were worthy, but not the services contracted.

Q-Ms. Hardtke has alleged that the actions taken by Shanti were intentional. The intent was to channel funds into areas not covered by Shanti's contracts. Ms. Hardtke asserts this was not accidental or an oversight, but intentional. A-Dr. Katz stated that intent is hard to track.

Gerald Lenoir stated that intent is the crux of the matter. If Shanti intentionally misled the AIDS Office and used funds in a manner that was inappropriate with its contracts, this is a serious matter. The intent is the most serious piece to be considered. Sandra Hernandez stated that areas of what was billed and actual costs is a question. If the AIDS Office was purposely misled, that is a serious problem. Gerald Lenoir reiterated that he wants the AIDS Office to look closely at intent and speak to this as an issue. Pat Christen stated that the question at hand is what was stipulated in the contract? Were monies expended consistently with contractual line items? The process used must be deliberative, the investigation aggressive.

Q-How much will the new audits cost the Planning Council? A-Audits are paid for out of the indirect expenses charged by an agency to a contract. The AIDS Office has not and will not offer to pay for the costs of the new audits.

Q-Why is the deadline for reconciliation of the contracts October 1, 1993? Why not earlier? A-The AIDS Office has placed tremendous administrative requirements on Shanti. The AIDS Office wants Shanti to continue to provide services while meeting these requirements. Shanti has until June 30, 1993 to reconstruct its housing contracts and the audit then takes approximately 90 days.

Q-There is a similarity between Shanti and A.I.D.S. in that there is mismanagement of funds. Intent is the question. Why not put Shanti in receivership as was done to A.I.D.S.? A-What caused the AIDS Office to place A.I.D.S. in receivership is that, while the AIDS Office was investigating A.I.D.S, the agency was cashing clients' Social Security checks to make payroll. Shanti is currently tracking funds correctly and contract modifications are being done correctly.

Elliot Ramos stated that there seems to be a double standard being used. Mr. Ramos stated that it appears, if an agency has the staff and resources to rectify a situation involving mismanagement of funds, it is acceptable to postpone recommendations to defund the agency.

Steve Lew stated he was very disturbed by the FY 1991-92 audit being inaccurate. Why is the audit inconsistent? Mitch Katz stated that the audit was inadequate for the amount of federal monies received by Shanti. He is unable to speak to why the audit has internal inconsistencies.

Q-The AIDS Office is making the assumption that the monies at Shanti were spent on client services? A-Yes. The AIDS Office feels the monies were spent on worthy projects.

Michael Shriver responded that he was uncomfortable with the judgment call of "worthy projects". Another agency apparently felt that making payroll for staff was "worthy" and had its contract defunded.

Pat Christen stated that Elliot Ramos raises a very important point on inconsistent standards. The Planning Council must go back to what is good for the clients being served. The Planning Council cannot consider receivership without being aware of the consequences. It would take several staff members from the AIDS Office, who would have to set aside their other responsibilities, to oversee

Shanti. While Ms. Christen is respectful of the fact that this feels inconsistent, there is a need for housing. With the size of the administrative requirements placed on Shanti, October 1, 1993, is not that far off.

Jerry Windley stated he is sick and tired of money going to pay back funds that were used inappropriately rather than going to services for persons with HIV. The Planning Council is being held hostage by a service provider. It seems to him that the Planning Council will go to any length or expense to keep the "AIDS business" going. Pat Underwood stated that the Planning Council cannot leave the public with the impression of two different standards. The representative payee program was defunded for breaking the law. If Shanti has broken the law, its contracts must be defunded. Someone else can be found to provide the service. Pat Christen concurred, stating that if there is a determination of illegal actions, this must be brought immediately to the Planning Council's attention. Sandra Hernandez stated that questions regarding double standards and public accountability are serious and will be treated accordingly.

B) The following motion was passed by the Planning Council with Bob Nelson and Scott Miller abstaining:

> To accept the AIDS Office recommendation of extending Shanti's contracts until October 1, 1993, pending the outcome of the AIDS Office investigation.

Valentine Aguirre stated that the Planning Council has a dangerous dependence on one organization providing essential services for San Francisco residents. The Planning Council needs to work to develop other resources for housing provision. It is not appropriate that the Planning Council must defer a decision due to the need for housing. If a situation of this sort occurs again, Mr. Aguirre expects protests and pandemonium. The Planning Council should not feel comfortable with the decision it reached tonight. Mr. Aguirre would like a commitment from the Planning Council that it will identify diverse organizations that can provide housing.

Ellen Hardtke stated that it is not difficult to prove intent in the case of Shanti. When offices are not open for months and invoices are submitted for services not provided, that is a very clear cut case. Shanti cannot say, "Oh, I forgot that there are only 11 flats open, not 14."

Sophia Chang stated that the draft "Defunding Process" sets a three step process for agencies experiencing difficulties: 1) recommendations for improving an agency; 2) a probation period for agencies who have an identified problem that requires specific actions that must be completed within a specific timeline; and 3) defunding for agencies that continue to be out of compliance.

03232gaa

1364 Masonic Avenue
San Francisco, California 94117
March 22, 1993

HIV Planning Council
San Francisco, California

Dear Members:

I have been a member of the Board of Directors of AIDS Indigent Direct services (A.I.D.S.) for one year now, and I am writing you to request that you reverse your decision to defund our agency until you review the recommendations of the San Francisco AIDS office when they complete their investigation of A.I.D.S. and our response to their report.

We at A.I.D.S first became aware of $36,000 missing from our Representative Payee Program in late January, 1993, and promptly informed the city AIDS office and planned to inform the city attorney's office until we were advised not to do so by the city AIDS office. Our own internal investigation has discovered that all but $8,000 of the missing $36,000 was due to overpayment to clients who are still receiving services from us, unreturned security rent deposits on client accommodations, and bookkeeping errors. Mutually acceptable arrangements have been made with these clients to deduct these overpayments over time from their Social Security payments to rectify their accounts. The remaining approximately $8,000 is owed by clients no longer served by A.I.D.S., and this money has been replaced by monies from our general fund account gradually over the past two years. We currently have a $124 surplus in this account and will be able to continue to serve as Representative Payee for our clients if the San Francisco Health Commission allows us to do so.

In early March, 1993, our Executive Director deposited Social Security funds intended for our clients into our general fund account rather than into the Representative Payee account, in order to cover a one-day fund shortfall for our employee payroll. While no clients were denied funds due them during that time, the Board of Directors unanimously agreed that the action he took without board approval was inappropriate. For that reason and others, his employment was terminated March 10, 1993, and we appointed our board member, Ms. Audrey Doughtey, as interim executive director. She had served as temporary executive director in June and July, 1992, and had initiated fiscal reform policies and procedures which, unfortunately, had not been followed since then.

Additionally, our organization had undergone reorganization with the loss of some staff who had not been very productive and/or honest. Some other staff were given administrative responsibilities that, in retrospect, were somewhat beyond their capabilities and/or interest, which created animosity between them and the non-administrative staff, who were much more involved in direct patient management. These administrative personnel are no longer with A.I.D.S., but resolution of this problem has created ill will among these former administrators, which led to the recent inaccurate front

page articles in the San Francisco Examiner, beginning two weeks after A.I.D.S. notified the city AIDS office of the missing $36,000.

I would like to address some of the charges in the Examiner, specifically:

1) The city AIDS office has long been aware that A.I.D.S. has not raised $200,000 in private money. It has been more the rule than the exception that smaller AIDS organizations have not met the 30 percent of total budget goal that the Health Department would like to see in donations. This is even more difficult when these organizations are not allowed to participate in some of the larger fundraising events, such as the AIDS Walk, Danceathon, et cetera.

2) Most services we said we provided were provided for our clients. There were allegations that one of our employees provided brief or marginal contact services. That employee was terminated last summer.

3) We have raised approximately $19,000 through the African-American church community, and by direct mail solicitations of our friends and associates, and are currently utilizing the services of Ms. Jude Kay of the Support Center to develop a long range plan for A.I.D.S. which will include long range fundraising.

4) The $5,000 check written by a former officer of A.I.D.S. was to repay a $5,000 no-interest loan which his partner kindly made to A.I.D.S. to cover a funding shortfall.

5) We have amended our by-laws to allow our board to consist of four to fifteen members and currently have five members (three men and two women, three African-Americans, one Caucasian, and one Hispanic) and intend to continue recruiting until we have nine or more members.

Caring for our indigent citizens with AIDS and substance abuse is at times challenging yet personally rewarding, and I have great admiration for our dedicated staff and our clients, our very vulnerable survivors whose care prior to the inception of our organization was intermittent and fragmented at best.

Sincerely yours,

Henry H. Mally, M.D.

Henry H. Mally, M.D.

Remarks to the City and County of
San Francisco Ryan White Care Council
Monday, 22 March 1993

By Albert D. Cunningham,
former board member and former interim executive director,
AIDS Indigent Direct Services
824 Fell Street, San Francisco, CA 94117, +1 (5/8o1-3702

I am pleased to have the opportunity to come before you and speak on a number of issues which are of great concern to me, and for which, up until this time, I had found no appropriate forum. I have been involved in AIDS-related activities around the country for more than five years, and therefore believe I speak from a perspective of some experience about community-based AIDS service organizations.

I joined the board of directors of AIDS Indigent Direct Services in March, 1992, in response to urging by the late Preston Nicholson, one of the organization's founders. Like many CBOs, I knew A.I.D.S. was facing managerial and administrative difficulties, but I was more than convinced of the critical importance of the services provided and the sensitivity and "tough love," if you will, with which they were and are provided. I need to say at the outset that my conviction in this regard is unchanged. No other organization presently in existence is in a better position to serve the hundreds of clients in the Tenderloin which A.I.D.S. serves: poor, disenfranchised, substance using, psycho-socially maladjusted, manipulative people in most instances, but still, sick and dying human beings deserving of treatment with dignity and concern.

Within two months of joining the board of directors, I was asked to assume the position of interim executive director upon the resignation of the agency's founder, Michael Freeman-McGuire. Aside from maintaining continuity of services and reassuring a staff which

had been buffeted by a series of administrative and management upheavals, I felt my most important responsibility to be assessing and gaining control of the agency's fiscal status. At the time, the agency had no full-time fiscal administrator or bookkeeper. Within the narrow budget constraints which I found, I managed to hire a full-time fiscal administrator and a work-study graduate of UC Berkeley to begin to "get a grip" on the agency's fiscal condition. I also sought help through the Support Center, which I must report was virtually useless. Meetings with Support Center representatives were difficult to schedule due, it seemed, to their excessive caseload. When I did finally meet with someone who was to assess the agency's needs, I left the meeting with the impression that the Support Center rep had no better notion than I of how to begin to address the agency's difficulties, and no sense of how to even advise me to look for assistance. Appointments with other Support Center consultants who might be able to assist could not be made until weeks into the future. The inability of this organization, highly touted by the AIDS Office, to be of assistance was a major disappointment. Nevertheless, with what expertise was available, we began to assess the agency's fiscal condition and to consider means by which to rectify deficiencies. This process continued after my interim tenure, under another interim exceutive director, board member Audrey Doughty, who serves in that capacity at present.

One of the most significant discoveries which resulted from our summer work-study accounting internship was that the agency had, in a number of instances, overpaid clients. That is, the clients were

given more money than they actually had coming to them. In many cases, this was the result of rent deposits paid to landlords that were never recouped in the gradual, monthly fashion they were supposed to have been. To some degree, this problem had been mitigated by a new contract with the City that provided for some losses in the deposits for one reason or another. Mostly, tho, failure to return the money to the revolving deposit fund was the result of ineffective administrative oversight. This is an important fact, as it refutes directly one of the more serious charges levelled against A.I.D.S.

For the purposes of brevity, I would like to fast-forward several months to the end of 1992. By this time, the agency had a permanent executive director, Douglas Benbow, and I had resumed my position on the board of directors. One of the tasks I had accepted was the recruitment of new board members, as part of a committee of three. This was not an easy task, as most of the people who appeared suitable were already over-committed or otherwise preoccupied. One person suggested from within the agency was an employee of the Shanti Project. At a board meeting, I stated misgivings about bringing someone onto the board with such an obvious potential conflict of interest. I also mentioned a conversation with the executive director of Shanti in which I felt he expressed a less-than sensitive perspective on the clients A.I.D.S. serves.

I gave this discussion no more thought until I received a voicemail message from Eric Rofes a few days later, suggesting that he had heard I had some issues with him, and offering to discuss them. I

was amazed at the inappropriateness of this board conversation having travelled to him, and at his audacity in responding to it. I did not return the call, and did not realize what it might portend.

Following a board meeting February 4 at which there had been no discussion of storm clouds forming, I was preparing to go out of town February 10 when I began receiving phone calls informing me of a "bombshell" on the front page of the *Examiner*. I picked up the paper at the airport, to discover what became the first of a series of articles by the *examiner's* medical writer, Lisa M. Krieger. Reading this front page "news" story, I could not help but find it incredible that any daily would print such a missue of misstatements, misrepresentations, and out-and-out fabrications, all attributed to un-named "sources," and on the front page of the paper, no less! I was also appalled that nowhere were there any indications that the writer made an effort to provide any balance in the story. Certainly, I had never been called, and I am readily available by phone. I later discovered that only one board member had been contacted, late the night before the story was to run. Interestingly, one of the few on-the-record quotes in the article came from Eric Rofes, who claimed ignorance of the agency's internal operations. One of the principal allegations of the article was that clients' rent checks had bounced. Incredibly, the figure cited was the same amount our audit of the representative payee program showed had been *overpaid* the clients! And so it went, right down the line: Information well-known within the agency and reported to the AIDS Office was twisted to appear as though the agency was intentionally

misleading its funding source. The integrity and professionalism of individual staff members was impugned, while references to services not being provided were in some cases traceable to the very "sources being attributed, whose identities were fairly easy to deduce by anyone familiar with the agency's internal politics. To further confirm their identities and add yet another fascinating "coincidence" to this bizarre scenario, within a few days of the appearance of the first article, I received a letter from a man who happens to be both the partner of one of these disaffected A.I.D.S. employees and a Shanti Project employee, claiming credit for the *Examiner* series and vowing to continue his "crusade."

I think it is important to take serious note of just how dangerous and damaging such reckless and irresponsible journalism (if such it can be called) can be, and in this case, has been, since it obviously influenced this body's actions so emphatically. Furthermore, in a recent meeting with representatives of the local HIV/AIDS CBO community which I attended, Ms. Krieger informed us that:

1. Her "sources" for this series of articles were provided by one person, and she made no effort to investigate further.

2. That she uses the same gay white men as resources for her AIDS stories because she is familiar with them and can call them at home, despite the increasing shift of the epidemic into communities of color and the availability of people of color who have been involved in the epidemic since "Day One."

3. That her efforts to contact members of the board of directors of A.I.D.S. or others who could have provided her articles

with more balance were minimal at best. Indeed, the only quote from a board member in the first article was taken completely out of context from a letter that person wrote, attempting to correct misstatements in an earlier article Krieger had written!

As a journalist for 30 years, I was appalled at her attitude, which was both condescending and impervious to any constructive criticism. While when pressed, she half-heartedly agreed to be inclusive of a more diverse range of perspectives in future, one can only wait and see. I will certainly not hold my breath.

Through it all, the staff at A.I.D.S. has remained dedicated to its more than 300 clients, though the internal and external pressures have resulted in the loss of valuable employees. In the midst of rumored and proposed consolidations of services that would likely eliminate smaller agencies with insufficient cash flow to sustain larger payrolls, one wonders whether the least of these, clients such as those served by agencies like A.I.D.S., will fall through the cracks. They have no strong, organized lobbying force to put their case, nor friends in advantageous positions within the media to shield them from criticism and trumpet their virtues. They are hundreds of people whose lives literally hang in the balance.

There can be no doubt that A.I.D.S. has suffered from poor management and administration. But neither can there be any doubt that solutions to many of the agency's problems were sought, long before the AIDS Office took the step of detailing someone to the agency to oversee the minutiae of every transaction. It seems to me that it behooves this council to do several things:

1. To protest the reckless and totally biased coverage of

A.I.D.S. by the *Examiner*, particularly in view of the amazingly delicate treatment of far more serious allegations against Shanti Project, with which the writer has a longstanding relationship. Small agencies serving predominantly people of color should not be accorded special treatment, but neither should larger "mainstream" organizations. It is much more difficult for smaller agencies to rebound from criticism, founded or otherwise, and they are usually already working from the disadvantage of having to fight communities in denial and avoidance of the basic issues.

2. Reconsider and rescind the decision to de-fund A.I.D.S., pending further investigation and at least a determination of how these critical services would be provided to this community in its absence. Even in difficult budgetary times, there is no justification for harming most those who are least able to fend for themselves, much less raise sufficient hue and cry to affect the outcome. As guardians of the public trust, it is to *these* citizens of San Francisco to whom this council should feel its primary obligation.

3. Finally, I would urge the council to do whatever it can to insure that sufficient administrative and managerial technical assistance is available to every funded organization under its aegis. This assistance should be both culturally appropriate and specific to the needs of the agency in question. As we have seen in HIV education and prevention, the mainstream, "broad brush" approach to problem-solving and systems building is not always effective among people of color. Thank you for your time and attention.

AIDS Indigent Direct Services
25 Taylor Street - #714
San Francisco, CA 94102
292-5460

From: Audrey K. Doughty
Interim Executive Director

STATEMENT FOR THE HIV PLANNING COUNCIL - March 22, 1993

Quality of Services

Neither the Planning Council in its vote to defund AIDS Indigent Direct Services nor the AIDS Office in its investigation of the agency have given consideration to the quality of the services being provided by A.I.D.S. Throughout its four years, first as a volunteer organization and later as an agency receiving government funds, it has provided a client population living in difficult circumstances -- a client population that few agencies are willing to serve -- with a variety of services given by exceptionally dedicated volunteers and staff. I say that they are exceptionally dedicated because it is very stressful working in the Tenderloin and working with the client population there. The frustrations are enormous and not easily mitigated. Coping with the anger of clients, sane and demented, being alert to the ever-present dangers of working among people who are homeless or in the worst housing in the city, financially deprived, physically and mentally ill takes a special love of humanity few people have.

There are rewards. Recently a volunteer was in the Ambassador Hotel, and an A.I.D.S. client came up to her and said: "Do you remember me? I remember you because you and your friend worked so hard for us at the Christmas party."

That is the kind of dedication that A.I.D.S has given to the community, and it does not deserve to be done in by a sensation-seeking reporter.

Has she followed up her article on A.I.D.S. with one stating that the executive directorwas terminated for using Social Security funds to cover the payroll? No. Has she written that although this happened, no client's funds were unavailable to him or her at any time? No. Has she written that Social Security does not require a separate account for the funds it entrusts to A.I.D.S. and that they could have been comingled on a continuing basis? No. Alas, we did not do that and had separate accounts to be more fiscally accountable. The director thus made an unfortunate error in transferring the funds for 24 hours.

Has she written that there is no evidence at A.I.D.S. of any missing funds and that A.I.D.S. is guilty only of overpaying some of its clients in its money management program? No, she has not!

With reference to one of her earlier stories, has she said that the story she wrote on the client whose confidentiality she breached by taking her to lunch and eliciting a totally false statement from her in return therefor was untrue from start to finish? The client was never denied any funds, and, in fact, was lent a sum of money she did not have coming to her to cover the rent on the strength of a promise that her mother would pay us back. We had no assurance that her mother would pay us back, but she did.

Has Lisa Krieger been informed by the AIDS Office that the AIDS Office recommended that during its investigation staff members not be terminated and that therefore the board of directors did not take action to terminate the director before the deposit of Social Security funds was made in the general account? The director was on a 60-day probation with specific tasks to be completed by specific dates. These had not been met, and three of the five board members wanted to terminate him. The other two prevailed on them not to vote because of the AIDS Office recommendation.

The Denial of Due Process

The Examiner did do one thing for us. It did inform us that A.I.D.S. had been placed by the AIDS Office in receivership. We had not and still have not received anything in writing to confirm this nor have we received any policies and procedures for the conduct of the receivership.

What is due process here? We request a fair hearing, an opportunity to show that we have corrected our errors, an opportunity to counter inaccurate statements that have been made about A.I.D.S., its management and its services.

We also request that we be treated in the same manner as other agencies under contract with you are treated. We understand Shanti has enormous problems. Has the AIDS Office volunteered information to Lisa Krieger without benefit of review? Definitely not. We understand, in fact, that every effort has been made and quite successfully to conceal this matter from the public. Even more important, has Shanti been defunded? Definitely not.

Our inadequacies are minimal by comparison. We have not billed the city for things we haven't done.

We ask that we not be singled out for retribution and that we not be tried by the press and found guilty by the press.

City and County of San Francisco

Department of Public Health

DOCUMENTS DEPT.
MAR 15 1993
SAN FRANCISCO
PUBLIC LIBRARY

ANNOUNCEMENT OF SPECIAL MEETING

HIV HEALTH SERVICES PLANNING COUNCIL
March 29, 1993
25 Van Ness, Third Floor Conference Room
4:30 - 7:30 p.m.

AGENDA

I. Roll Call

II. Review of Agenda and Minutes

III. General Announcements

IV. People of Color and HIV Report
   a. Review of Recommendations in the Report
   b. Facilitated Discussion by Deborah Johnson

V. Public Comment

03123gda

AIDS OFFICE

25 VAN NESS AVENUE, SUITE 500
SAN FRANCISCO, CA 94102 - 6033

415 - 554-9000
FAX 415 - 431-7547

F
122
2
3/29/93

DOCUMENTS DEPT.
APR 6 1993
SAN FRANCISCO
PUBLIC LIBRARY

HIV HEALTH SERVICES PLANNING COUNCIL
March 29, 1993
4:30-5:30 p.m.

Minutes

Members Present: Marcy Fraser, Yvonne Frazier, Estela Garcia, Gerald Lenoir, Steve Lew, Elliot Ramos, Steve Roger, Laura Thomas, Mary Jane Wood

Members Absent: Sandra Hernandez, Reggie Williams, Pat Christen, Jaime Geaga, Les Hanson, Karen Hembry, Kent Macdonald, Scott Miller, J.B. Molaghan, Bob Nelson, Eric Rofes, Mike Shriver, Pat Underwood, Jerry Windley

Staff Present: Sophia Chang, Bill Haskell, Jon Dean Green

Guests: Rafael Chang, Valentine Aguirre

Facilitator: Deborah Johnson

I. Roll Call

Roll Call was taken as above. A quorum was not present.

II. Review of Agenda and Minutes

A quorum was not present. Approval of the March 22, 1993, minutes was deferred to the April 12, 1993, meeting.

III. General Comment

Gerald Lenoir stated that it was very disrespectful both to the facilitator and to the discussion of the *People of Color and HIV/AIDS* report that so few members were present. Mr. Lenoir stated that Ms. Johnson should be paid for her time and the discussion rescheduled for a later date.

Valentine Aguirre stated that the point of the meeting was not to have a presentation of the report, but was intended to give information to the Planning Council to inform its decisions on issues concerning services to People of Color.

Estela Garcia concurred stating that the Planning Council had made the decision to have this meeting to fully discuss issues which affect resource allocation by the Planning Council.

The consensus of the members present was that the meeting should be rescheduled for April 19, 1993. A letter should be sent to Planning Council members reminding the members of recent discussions concerning services for People of Color and the need to have a full and in-depth discussion of the issue. The members thanked Ms. Johnson for her time and apologized that the Planning Council had postponed her facilitation of the discussion on two occasions.

Sophia Chang stated that she would be attending a meeting held by the Health Resources and Services Administration (HRSA) on Thursday, April 1st. Dr. Chang stated that the purpose of the meeting was to have consensus on the variables needed by HRSA for the Needs Assessment. Dr. Chang stated that HRSA had originally asked for detailed data beyond the current ability of Title I cities to provide. She stated that it appeared that HRSA was looking for information on total need, what services are provided, and a quantified estimate of unmet need. Dr. Chang stated that a lack in San Francisco's needs assessment was that no client survey had been performed. She and Jon Dean Green along with Rani Marx of the AIDS Office will be formulating a draft client needs instrument.

Q-Is the purpose of the needs assessment to determine unmet need, or for information to reauthorize the CARE Act? A-Reauthorization seems to be the motivation for the needs assessment.

The consensus of the members present was that Dr. Chang should work with HRSA to develop a reasonable needs assessment that will provide useful information both for the EMA and HRSA that will not be unduly burdensome to the providers collecting the information.

Bill Haskell stated that Dr. Ray Baxter will be presenting the Department of Public Health Budget to the Health Commission on Tuesday, April 6 at 3:00 p.m. in the Board of Supervisors Chamber at City Hall.

Sophia Chang stated that AIDS Office was moving forward with long-range planning. Dr. Chang stated that there are currently a number of groups looking to the issues of long-range planning for health care. The Planning Council's role should be to map out the ideal system for service delivery from the client perspective. The system envisioned should be "user friendly." The Planning Council should develop a plan that maps out how to go from the present decentralized fragmented system to a system that ensures accessibility and greater efficiency. This will allow the Planning Council to have a goal in mind when working with other health care system plans.

04013gaa

HIV HEALTH SERVICES PLANNING COUNCIL

April 12, 1993

The Agenda of this meeting is missing.

San Francisco Public Library
Government Information Center

SF
422
#2
12/93

HIV HEALTH SERVICES PLANNING COUNCIL

April 12, 1993
4:30-7:30 p.m.

MINUTES

Members Present: Sandra Hernandez, Reggie Williams, Pat Christen, Marcy Fraser, Yvonne Frazier, Barbara Garcia, Gerald Lenoir, Gifford Leoung, J.B. Molaghan, Bob Nelson, Steve Roger, Mike Shriver, Laura Thomas, Rita Times, Mary Jane Wood

Members Absent: Estela Garcia, Jaime Geaga, Les Hanson, Karen Hembry, Steve Lew, Kent Macdonald, Scott Miller, Elliot Ramos, Pat Underwood, Jerry Windley

Staff Present: Bill Haskell, Valerie Dorr, Mitch Katz, James Loyce, Herman Levias Jon Dean Green

I. Roll Call

Roll Call was taken as above.

II. Review of the Agenda and Minutes

The minutes of March 8 and March 22 were approved. Barbara Garcia and Rita Times abstained.

III. General Announcements

There were no general announcements.

IV. Update on Supplemental Augmentation

Tom Sheridan of the Sheridan Group spoke on behalf of Cities Advocating Emergency AIDS Relief (CAEAR). Mr. Sheridan stated there was good news and bad news. The good news is that President Clinton ran on a platform committed to funding the CARE Act. President Clinton has proposed an additional $85 million for Titles I and II, $25 million for Title IIIb and $20 million for Title IV in his "Economic Stimulus Package." The House of Representatives has passed the package, but it has become derailed in the Senate. The Democrats in the Senate are unable to reach cloture. Senator Dole stated that the Republicans in the Senate will not accept anything in the package except the unemployment benefits piece. President Clinton may not have the votes to pass the package. Mr. Sheridan stated that Republicans who are often friendly to social packages i.e. D'Amato, Danforth, Durenberger, Hatfield are key. Mr. Sheridan encouraged Planning Council members to ask Senators Boxer and Feinstein to take the position that they will not vote for the package at all if CARE monies are removed. Mr. Sheridan stated that his opinion was the package has approximately a 30% chance for passage. If the monies do come through, the funds may be a Formula allocation.

Mr. Sheridan stated there are 11 new Title I cities. The proposed $336 million for CARE in Y04 will adequately cover the needs of current Title I cities and the needs of the new Title I cities.

(In a conversation with HRSA subsequent to the above, Sheila McCarthy stated that due to changes under consideration at the Centers for Disease Control regarding census data and reconfigurations of

Metropolitan Statistical Areas (MSAs), HRSA only has preliminary information on areas that qualify to be Title I Eligible Metropolitan Areas (EMAs). The areas that have reached 2000 cases for Y04 are Riverside/San Bernadino, Phoenix, Denver, St. Louis, Kansas City, West Palm Beach, Orlando, and New Haven. The question that remains unclear is whether counties that are in New Jersey will be counted for statistical reasons with New York or will become independent eligible areas. This might bring the number of new EMAs up from eight, to nine or even ten. Jersey City has passed 2,000 cases and Ponce, Puerto Rico is now the only EMA eligible for Title I monies under per capita rate as opposed to cumulative rate. Caguas, Puerto Rico is the only city that just missed the 2,000 cut off point for qualification as a Title I eligible EMA. jdg)

Mr. Sheridan stated the bad news is that San Francisco and the problems at Shanti are being discussed in Washington. There are a number of groups that are looking for a chance to criticize what they perceive as an overspending on AIDS. The public relations problem being created by what the press refers to as mismanagement of CARE funds makes it difficult to sell additional CARE funding to Congress. The problems are tainting the entire CARE program. To maintain its credibility San Francisco must manage the crisis well. The spin Mr. Sheridan is putting on the issue is that Planning Councils were specifically created to handle this type of problem. By discovering the problem and handling it in a forthright manner, the Planning Council is demonstrating accountability and responsibility. The Shanti problem came at a very bad time. The Sheridan Group had been planning on bringing a group of six Congressmen to San Francisco to demonstrate the success of CARE. The plans were canceled. Mr. Sheridan explained to the members that it was not a matter of monies being wasted, but rather accounting problems. Mr. Sheridan hoped that further discoveries at Shanti would not prove his statement to the members wrong. That would damage both his and San Francisco's credibility and reputation.

V. HOPWA Notice of Financial Availability Update

Bill Rumpf of the San Francisco Redevelopment Agency (SFRA) stated that he had met with the HIV Housing Network. (Refer to the enclosed handout.) It was the recommendation of the HIV Housing Network that more monies be put towards lease and rental assistance and less towards capital expenditures for Y02 of HOPWA. Mr. Rumpf stated that in Y02, the SFRA will be allowed 3% for administering the monies and agencies 7%. The monies for Y02 will be following Y01 monies by six months. Mr. Rumpf is unsure if the system can absorb the additional influx of funds.

Q-What was the framework for the formulation of the recommendations? A-(Bob Nelson) There was a strong feeling among the 30-40 housing providers present at the meeting that with the opening of several large capital projects that focus on congregate housing, there was a need for subsidies to keep persons who might not want or be appropriate for congregate housing in their present living situations.

Sandra Hernandez reminded the Planning Council that CARE monies did not allow for capital expenditures. The Planning Council had originally intended for HOPWA monies to fund projects that by legislative mandate CARE could not. Dr. Hernandez asked what would be the reason for funding services under HOPWA that CARE could pay for?

Bill Haskell stated that the AIDS Office is negotiating CARE contracts now. He is unsure of the capacity for additional housing.

Q-What type of logistical problems would be involved in moving housing contracts from CARE to HOPWA? A-The contractual timeline cycles are off. Contracts for HOPWA will not be in place till August at the earliest. A shift from CARE to HOPWA would cause a break in service.

Bob Nelson stated that long term subsidies, especially for families is an issue. The HIV Housing Network was not expecting a shift in current CARE contracts to HOPWA. It was looking to additional monies above the current programs.

Pat Christen stated that housing providers are having a difficult time placing active users in the early stages of recovery. Housing providers are unable to find safe housing for persons using or just getting out of substance abuse.

Q-If the system is unable to absorb all of the HOPWA monies by the end of round 2, will the monies have to be returned to Housing and Urban Development (HUD)? A-No. HUD regulations for HOPWA allow three years for the monies to be spent.

Mary Jane Wood stated that a jump from $10,000 in lease/subsidies to $1.5 million seems too large. There are no quantifiables available on the number of persons needing housing. Ms. Wood stated the proposal would limit the flexibility of the SFRA regarding capital projects.

Bob Nelson stated the number one need in housing is the ability to keep persons housed who are not appropriate for congregate living sites.

Sandra Hernandez stated that without a needs assessment, providers are the only ones able to speak to the present need for housing. There is a need for an assessment that will examine numbers of persons needing housing, modality needed, and appropriate locations.

A) The following motion was passed by the Planning Council with Pat Christen and Bob Nelson abstaining:

> To ask the San Francisco Redevelopment Agency to accept the recommendations from the HIV Housing Network and other changes contained in the April 12, 1993 memo from the SFRA regarding HOPWA monies.

VI. Update on Copayment Consultant

Herman Levias, AIDS Office, stated that the AIDS Office is at the starting gate with the revenue enhancement and copayment system project. Castle Rock Consulting Group is the contractor who will develop a feasibility study for maximizing reimbursement and meeting the mandates of the CARE legislation which requires client copayment for CARE services. If copayment is not feasible under the San Francisco model, the City must document this with solid information. One of the focuses of the project will be having AIDS Service Organizations (ASOs) who are able to bill MediCal for services do so and at the maximum amount allowable.

Q-Is there a document available to the Planning Council and for providers that explains why this work is being done? A-Yes. Herman Levias will provide the Planning Council with the documents.

Q-Will copayment services be looked at for the EMA as a whole? A-No, only for San Francisco.

Q-What is the timeline for completion? A-The contract runs through June. The expectation is that the process will actually be completed by August.

VII. Approval of the Title II Letter of Intent

Jon Dean Green stated that San Francisco was eligible for $746,299 in Y03. This is an increase of $63,390. The letter of intent is the first part of the process in which San Francisco informs the State it will be applying for the funds.

B) The following motion was passed by the Planning Council:

To send a letter of intent to the State to apply for CARE Title II monies.

VIII. A.I.D.S. and Shanti Updates

(Refer to the enclosed handout.)

Mitch Katz, AIDS Office, stated that in regard to both agencies, renewals of the current contracts had been brought before the Health Commission to prevent breaks in services to clients.

Sandra Hernandez stated that the media is driving the information flow on Shanti. The intent of the AIDS Office is to report information to the funding agencies. The Department of Public Health must communicate with HRSA that San Francisco must be allowed to complete its investigation and leave the responsibility with the City in regard to continuing to contract with Shanti. Concern for continued services to clients is the driving force for the Department behind continuing current contracts.

Mike Shriver stated that point three on Shanti is a major concern. Mr. Shriver asked how the information was discovered? A-The working papers from the auditors referred to the interest payments. The promissory note referred to stated that if Shanti were unable to pay the loan, the loan would be repaid from monies received from City and County contracts.

Q-Due to overpayments to Shanti between now and June, $267,000 will be deducted from payments to Shanti? A-Yes.

Q-Will service delivery be affected? A-Shanti had a $200,000 reserve. This leaves a $60,000 negative amount. Shanti stated they will be able to meet this amount.

Q-What happens to the monies being returned? A-There was ~$20,000 in Formula contracts, the remainder in Supplemental contracts. HRSA stated this money cannot be reallocated.

IX. DPH Budget Update

(Refer to enclosed handout.)

Sandra Hernandez stated the four options proposed in the DPH Budget update are not mutually exclusive. The Health Commission has uniformly denounced options two and three. All four options were sent on to the Mayor with a letter of support for options one and four and no support for two and three. The budget for the City will be put together in the next few weeks. The proposed budget may include negotiations with labor, tax discussions and service cuts.

Q-Will the proposed budget effect San Francisco's maintenance of effort under Title I? A-No.

Q-Will the DPH take a $25 million budget cut? A-The Health Commission unanimously opposed service cuts. Dr. Hernandez stated she is unclear if policy above the Health Commission is in favor of taking part in managed care. Any further service cuts will devastate the system and change it dramatically.

Dr. Hernandez stated that when the Mayor was present to speak to the issue of the City budget, the Planning Council involved the Mayor in a political debate on health commission and board of supervisor appointments. This left Dr. Hernandez in an uncomfortable situation with the administration. When inviting public officials to meetings, the Planning Council should be clear on its intent and agenda.

Dr. Hernandez stated that currently there is discussion on reauthorization of the CARE Act legislation. One frustration with the current legislation is the 5% administrative cap. This does not allow the administering agency to deliver appropriate technical assistance. One option might be to suggest that any city receiving over $10 million in CARE funds should put a certain amount of money into technical assistance. Mike Shriver added that the Planning Council must examine the CARE system and speak to Congress regarding reauthorization. The process must be complete by Y04 to have reauthorization done in a timely manner.

X. Probationary Process/70% Rule Compliance-Enforcement

(Refer to enclosed handout.)

Bill Haskell stated that the underlining indicates changes from the first draft. Sandra Hernandez stated that the Planning Council has a need for a well spelled out process to handle problematic contracts. Dr. Hernandez asked the Planning Council members to read the document from an agency perspective and assess the document for appropriateness and accountability.

Planning Council members raised concerns regarding delays in payment, scores not being changed, and who should be notified of actions being taken by the Planning Council. The consensus of the Planning Council was that the second option under point twelve was more appropriate. This would make the process more closely resemble the RFP process and take the Planning Council a step back from conflict of interest.

Bill Haskell stated he would make further changes on the draft probationary process and present the changes back to the Planning Council and the AIDS Office advisory bodies.

The 70% Rule Compliance and Enforcement document was handed out for discussion at a later meeting.

04223GAA

HIV HEALTH SERVICES PLANNING COUNCIL

April 19, 1993

The Agenda of this meeting is missing.

San Francisco Public Library
Government Information Center

SF
H22
#2
4/19/93

SF

HIV HEALTH SERVICES PLANNING COUNCIL

April 19, 1993
4:30 - 7:30 p.m.

Minutes

Members Present:	Sandra Hernandez, Reggie Williams, Marcy Fraser, Yvonne Frazier, Estela Garcia, Les Hanson, Susan Karp, Gifford Leoung, Kent Macdonald, Scott Miller, Elliot Ramos, Steve Roger, Laura Thomas, Rita Time, Jerry Windley, Mary Jane Wood
Members Absent:	Pat Christen, Jaime Geaga, Barbara Garcia, Karen Hembry, Gerald Lenoir, J.B. Molaghan, Bob Nelson, Pat Underwood
Staff Present:	Sophia Chang, Bill Haskell, Jon Dean Green
Facilitator:	Deborah Johnson

I. Roll Call

Roll Call was taken as above.

II. Review of Minutes

The minutes of the April 12, 1993 meeting were not yet ready for review.

III. Facilitated Discussion of the People of Color HIV/AIDS Report

Reggie Williams introduced and welcomed Ms. Deborah Johnson of the Motivational Institute as the facilitator for the meeting.

Sandra Hernandez presented a brief backdrop for the report. Dr. Hernandez stated the report was a cooperative effort paid for by a Community Development Block Grant (CDBG) from the Mayor's Office, the United Way of the Bay Area, and the Levi Strauss Foundation. It originally was proposed to assess needs for Prevention services to Communities of Color. The People of Color Advisory Committee proposed that the report instead examine capacity for services to Communities of Color. Dr. Hernandez stated the contents are critical in an era of consolidation and collaboration.

Dr. Hernandez stated the report is very timely. The Planning Council is currently engaged in a learning process in regard to service delivery to People of Color. The Planning Council continues to review and clarify its ideas on service delivery. Previously the Planning Council had used the RFP process to try and address further services to Communities of Color by Communities of Color. Dr. Hernandez stated this was a remedial approach to a bigger problem.

Deborah Johnson stated that the discussion would begin with the various communities presenting their perspectives on the report.

Rafael Chang, Asian Pacific AIDS Coalition (APAC) Mr. Chang asked the Planning Council to examine the report closely. For the Asian/Pacific Islander community, language services are the most important aspect, especially as it relates to recent immigrants. There is a large need for culturally and linguistically appropriate services. Currently, Asian AIDS Project and GAPA Community HIV Project (GCHP) are in the process of merging. The agencies are not merging due to a lack of cases, rather they are attempting to provide better services to clients. Mr. Chang stated that some people have perceived the report as stating that only culture specific services work and multicultural approachs do not. This is untrue. The report rather emphasizes that some services need to be culturally specific. Language is a key issue.

Q-What specific language capacities are needed? A- Informal statistics indicate there is a need for Vietnamese, Korean, Cantonese and Mandarin services. APAC discussed a language bank to provide interpreter services. This would allow numerous agencies to access interpreter services. A problem is that the interpreter may know the client and this would impact client confidentiality. Another problem might be the inability of an interpreter to understand a dialect different from the interpreters. GCHP has addressed the need for language specific services by having case managers who are polyglots.

Q-Could the current Asian/Pacific Islander agencies develop this service? A-Current agencies do not have the infrastructure to develop a project of this size. If the service were to be developed at a larger agency, there would be questions similar to those regarding the effectiveness of the Tagalog Hotline at the San Francisco AIDS Foundation.

Rafael Chang stated that one problem is there is no remuneration associated with being multilingual. Clients need staff or volunteers who can accompany and help them access the continuum of care during the entire course of the client's illness. This can lead to staff/volunteer burnout.

Les Hanson, American Indian AIDS Institute (AIAI) Mr. Hanson stated that the process used to prepare the report was unique. It was a collaborative effort of the four major ethnic groups. Mr. Hanson stated that the report's inclusiveness is important to Native peoples. Often when People of Color are discussed, Native Americans are neglected. Having a Native American voice strengthens and validates the report.

Mr. Hanson stated that a primary issue for Native peoples is the lack of statistics regarding cases and needs. Many Native Americans are classified under the category of "Other." A study recently conducted in Los Angeles documented six cases of Native Americans with AIDS. When community-based organizations were polled, an additional 50 cases were documented.

A fundamental issue captured in the report is that the San Francisco model is decentralized for a reason. There are numerous service organizations present in San Francisco because of the unmet needs previously experienced by under-served communities. The empowerment of Communities of Color is an important aspect of provision of care.

For Native American men, 1/3 will die before the age of 45. This speaks to the quality of health care available. Outreach is a key, with trust being the primary issue. Services must be brought to the streets. A majority of Native Americans with HIV will not access service delivery that is office based. Substance abuse treatment is the most needed service. This is a starting point for Native American services. In order to deliver HIV services, clients housing, food and income needs must be addressed

first. If a client doesn't know where they will sleep, if they'll eat, and have no money for food or shelter, their HIV concerns are very secondary. In order to be able to stabilize clients, substance abuse and mental health must be addressed. 90% of the clients seen at AIAI are dual/triple diagnosed. Mr. Hanson added that most of the current services delivered in San Francisco are designed for clients who know how to access services. The system was designed for the middle class. For Native Americans, substance abuse treatment is the place to start services. People in recovery are looking for a better quality of life.

Mr. Hanson stated that with the closure of the American Indian Center, there is not a heart for the Native community. People need to have a place to congregate and feel empowered.

Yvonne Frazier stated that Community Substance Abuse Services had just held a Bidder's Conference to announce the availability of Federal monies for People of Color with substance abuse and HIV.

Brenda Storey, Latino Coalition on AIDS/SIDA Ms. Storey stated there is a need for trust and consistency in the Latino community. Continuity is an issue. In previous years, the Latino community plotted out the available services and noted there was a continuum of care. Gaps have subsequently developed in the availability of services. Latino clients become confused when services are only available for a year or two. People of Color run out of energy when they are constantly fighting the same battle over a number of years. Ms. Storey stated that there is a balance between ethnic specific and multicultural services. Clients decide which they are more comfortable accessing. Ethnic based agencies must provide multicultural services also. The Latino culture should not be viewed as homogenous or monolithic.

The Latino community must deal sensitively with issues regarding the fears and concerns of immigrants. If a provider accepts emergency MediCal payment for a client and does not report a client as undocumented, the agency may not be reimbursed for the care. Also, the Department of Motor Vehicles will no longer issue an identification card without proof of a Social Security Card. In this way eligibility and identification necessary to receive services limits health care access.

Estela Garcia stated that there is a need to change policies to help prevent provider burnout. Burnout is often caused by people having to face the same bad or inappropriate policies year after year.

Reggie Williams, San Francisco Black Coalition on AIDS Mr. Williams stated that the opportunity for Communities of Color to collaborate presented by this report is of historic import. Mr. Williams agreed with Estela Garcia that the ability to change policy is a key concept. The ability to change policy is empowering to Communities of Color. Mr. Williams stated that the original system of AIDS delivery created a model to fulfill the immediate needs of persons with HIV. People of Color did not have a large part in creation of the model. Communities of Color have had to develop and implement models to meet their needs. Mr. Williams stated that a problem in Communities of Color in San Francisco is denial. AIDS is still viewed as a problem primarily affecting gay white men. The majority of cases of AIDS in men of color in San Francisco has been among gay/bisexuals. The Gay Men of Color Consortium has worked with communities and institutions to face homophobia. Mr. Williams credited Phil Tingley with describing a problem in Communities of Color as "oppression sickness." Oppression sickness describes the feeling that services developed in Communities of Color are lesser or not as good as mainstream services. Mr. Williams stated that he and Gerald Lenoir coordinate a meeting of African

American service providers. The gaps described in the report came out of those meetings. The hope is that the Planning Council will address service and infrastructure needs.

Q-What services should be ethnic specific and which multicultural? A-Prevention services must be ethnic specific. If you don't see or here people like you in prevention messages, you don't feel your at risk. Primary care can be multicultural. There is a need for African American specific substance abuse treatment.

Rafael Chang stated that there is a need for a process to evaluate services by People of Color to People of Color. There is a question of ability or providers to plug clients into support and care systems within their communities.

Q-How can the Planning Council evaluate the cultural competency of an agency? A-Ask this as a question on the client needs assessment.

Brenda Storey stated that multicultural agencies cannot have only one person on staff who performs all ethnic specific work. This causes burnout and can lead to poor service provision.

Les Hanson stated there is a need to recognize issues around women and elders in Communities of Color. Women and elders are the teachers for the young. Multicultural agencies that serve significant numbers of People of Color and do not collaborate with People of Color agencies are questionable.

Estela Garcia stated that empowerment of Community of Color agencies is vital. The Planning Council must have a policy and practice of supporting ethnic specific agencies. Ms. Garcia stated there is a need to go from People of Color agencies merely surviving into the agencies prospering. Ethnic specific agencies are an endangered species. In the past twenty years the number of Latino based agencies has gone from over 500 to 50. Ms. Garcia stated she supports multicultural services wholeheartedly, but not at the expense of ethnic specific agencies.

Les Hanson concurred with Ms. Garcia and stated that the bottom line is the ability to serve clients. Mr. Hanson stated that there is also a problem with institutionalized racism. Dominant society feels that it wants to take care of "minorities" and knows how to do it best. This is wrong. There have been too many examples lately of the media and public figures stating that money was given to People of Color community-based organizations and these organizations failed or mismanaged the money. People of Color community-based organizations cannot be evaluated in the same way as organizations that have been operating between 10-20 years. People of Color agencies are not as sophisticated.

Steve Roger asked if the Planning Council can fund community-based organizations while concomitantly examining the technical assistance needs of the agency. The Planning Council could ascertain what the agency needs to grow and prosper.

Rita Times stated that a problem may be that while the services being provided are good, the administration of the funds may be unsatisfactory. Ms. Times emphasized that women and children have large service needs also. Ms. Times stated that there needs to be more than an African American agency. An agency serving gay men may not serve well or at all women and children. The change in CDC AIDS case definition has increased by 17% the number of cases in women. There has been a 51% increase in the number of cases in children in the past year.

Deborah Johnson stated that an important point that must not be lost in the conversation is that Communities of Color have a large amount of expertise in service delivery. The gap is in how to provide service within the context of administrative rules and requirements.

Sandra Hernandez stated that often communities are spoken of as if they are monolithic. Agencies try and do everything for everybody. The important issue in access is the relationships that people build within a community to make the community inclined to use a service. Factors that affect utilization are acculturation, socioeconomic status, education, being out. Too often agencies are trying to do too much for too many with too little funding and too little infrastructure. Additionally, large People of Color agencies have not provided HIV services. There are a fair number of People of Color providers in the general community. They just may not be providing HIV services. There is a need to be more successful in drawing down human resources.

Joe Gonzales stated that most providers come from a particular class. It is hard to serve clients who are not from the same class background. Function level is also an issue. How do individuals interact both cognitively and effectively with service providers.

Sandra Hernandez stated that her hope for the discussion was that the Planning Council would address the dynamic of the Planning Council itself being a mini-bureaucracy. To what extent has the Planning Council replicated institutional racism? The Planning Council has oversight of $25 million which makes it very sensitive to accountability. It is difficult to reconcile this with the desire to avoid "double standards" and the very real issue that service providers are at different levels of expertise with organizational development. A question that also must be answered is a need for service as determined by whom?

Laura Thomas stated that the big agency v. small agency discussion is also important. Often "small" agency is used as a euphemism for a People of Color agency. Standards must have a bottom line. It is not the responsibility of the Planning Council to empower agencies, but it is the responsibility of the Planning Council to not build walls or put up barriers that make empowerment more difficult to achieve.

Sandra Hernandez stated that as the Planning Council speaks on issues of collaboration and consolidation, it must think in terms of big sharks and small fish. Empowerment means giving people the power to learn from their own mistakes and experiences. If there are failures, communities must examine how and why there was a failure, regroup, reconstitute and deal with the problem again. CURAS is a good example of this. While the agency might have "failed", the process led to the growth of gay leadership in the Latino community.

Mary Jane Wood stated that frequently small agency proposals submitted for funding had unrealistic expectations for cost. Salaries were too low. The Planning Council must take into consideration cost of service and whether an agency is running on a shoe string. The Planning Council needs to clearly communicate to agencies that it is appropriate to pay a decent salary and/or make full usage of indirects.

Estela Garcia stated that the Planning Council must avoid colluding in undermining agencies. It must take responsibility to provide an environment for success. Salary parity with the Department of Public Health is an example. There is an unspoken policy that community-based organizations salaries are lower and their staff worth less. This dynamic influences the ability of their staff to be policy setters.

Race/class/socioeconomic status all affect how the Planning Council members view issues. The Planning Council must examine itself to understand issues. Resource allocation is power. It is seductive to take on the exercise of power in a punitive manner.

Kent Macdonald concurred with Ms. Garcia. Mr. Macdonald stated that clients of AIDS Indigent Direct Services and Health Outreach Team gave testimony to the Planning Council on the importance of the agencies and the quality of services provided. The Planning Council must avoid acting imperiously and inflexibly. Clients are the bottom line and the Planning Council must never forget them.

Reggie Williams stated that he would like the Planning Council to address concrete concepts. Salary parity is a good example.

Scott Miller stated that the issue of money is important. If an agency looks broken down, has only one staff person, then the clients accessing service begin to feel they are second class citizens receiving second class service.

Rita Times stated that Planning Council could consider providing greater assistance to smaller agencies especially for legal and accounting matters. Sandra Hernandez concurred stating that a new way of providing technical assistance must be found. Bill Haskell stated that often technical assistance is provided when an agency is already in trouble, rather than before the agency reaches that point.

Sandra Hernandez stated she would like to see a diverse group of the Planning Council examine the report, the People of Color recommended allocations and the mission statement of the Planning Council and come up with four or five concrete ideas to work from.

Deborah Johnson stated the Planning Council should consider in developing the group inviting persons who provide technical assistance and community-based organizations to participate. Ms. Johnson added that the board of directors level is where some of the most important work needs to be done. Boards of directors are often the area where there is the least level of expertise.

The consensus of the Planning Council was to accept the document, for a subcommittee to develop working proposals, and to send a letter of formal recognition on the importance of the work to the authors.

The Planning Council formally thanked Ms. Deborah Johnson for the time and energy she gave to facilitate the discussion.

04223gba

F
422
F1
3/93

DOCUMENTS DEPT.
APR 28 1993
SAN FRANCISCO
PUBLIC LIBRARY

HIV HEALTH SERVICES PLANNING COUNCIL

MAY 3, 1993

25 Van Ness, 3rd Floor Conference Room

TIME: 5:OO -8:00 p.m.

TENTATIVE AGENDA

I. Roll Call

II. Review of Minutes and Agenda

III. General Announcements

IV. Update on Economic Stimulus Package

V. Update on People of Color Report

VI. Probationary Process/70% Rule Compliance

VII. Client Needs Assessment

VIII. Continued Funding for HIV Infusion Services

IX. Public Comment

(Please note the change in time for the May 3 meeting. Enclosed please find the April 12 & 19, 1993 minutes. Additionally, the Regional Plan and executive summary that will be discussed at the May 10 meeting are enclosed. I will be send out at a later date the locations for the May 10, May 24, June 14 and June 28 meetings. If you have any questions, please call me at 554-9078. Jon Dean Green)

04263gaa

AIDS OFFICE
25 VAN NESS AVENUE, SUITE 500
SAN FRANCISCO, CA 94102 - 6033
415 - 554-9000
FAX 415 - 431-7547

SF
H22
#1
5/3/93

SF

HIV HEALTH SERVICES PLANNING COUNCIL
May 3, 1993
5:00 - 7:30 p.m.

Members Present:	Marcy Fraser, Yvonne Frazier, Barbara Garcia, Lester Hanson, Susan Karp, Kent Macdonald, Scott Miller, J.B. Molaghan, Steve Roger, Mike Shriver, Laura Thomas, Rita Times, Jerry Windley
Members Absent:	Pat Christen, Estela Garcia, Jaime Geaga, Karen Hembry, Sandra Hernandez, Steve Lew, Gerald Lenoir, Bob Nelson, Elliot Ramos, Patricia Underwood, Reggie Williams, Mary Jane Wood
Staff Present:	Sophia Chang, Bill Haskell, Valerie Dorr, Judith Weld, Galen Leung, Mark Morewitz

DOCUMENTS DEPT.
MAY 10 1993
SAN FRANCISCO
PUBLIC LIBRARY

I. Roll Call

Roll Call was taken as above.

II. Review of the Agenda and Minutes

The minutes of April 12, 1993 were approved with the addition of a sentence at the end of section X, " The Probationary Process applies to both community-based organizations and the Department of Public Health receiving Ryan White CARE funds." The minutes of the April 19, 1993 meeting were also approved.
Abstentions: Rita Times, Barbara Garcia, Lester Hanson

III. General Announcements

There will be an open meeting on May 4, 1993 in Jean Harris's office to discuss current budget concerns and the Kaufman HIV Task Force.

There will also be a Public Health Coalition meeting on May 12, 1993 at 5:30 p.m. to organize efforts to prevent the severity of the expected city budget cuts.

IV. Update on Economic Stimulus Package

Mike Shriver announced that the Economic Stimulus package was passed by the House of Representatives but was caught in a filibuster by Senate Republicans; Senate Democrats could not get a Rule of Closure and therefore the issue was defeated.

A Supplemental Budget may be introduced in the Senate as a free-standing budget for Title I and Title II funds. The $200 million proposed for CARE in FY 93-94 is said to be tied to the Economic Stimulus package, but Congressional Staff have testified that this money is independent of any other budgetary package. There is no resolution at the moment on this funding issue.

Mr. Shriver also reported that HRSA has still not released the number of Title I cities to receive CARE funds in 1993 - 94.

V. Update on People of Color Report

A) The following motion was passed by the Planning Council:

To create a subcommittee to review the People of Color Report and make recommendations for future Planning Council action.

Members who volunteered to serve on this committee are Lester Hanson and Rita Times. Planning Council members not in attendance will be polled as to whether or not they would be interested in serving on this committee.

VI. Client Needs Assessment

Sophia Chang discussed the self-administered questionnaire that she, Jon Dean Green and Rani Marx (AO staff) developed to determine what services the clients feel they need. The instrument is a simple questionnaire with a fourth grade literacy level that will be translated into Spanish, Tagalog and Cantonese.

After being reviewed by the Planning Council's Subcommittee on Evaluation, the questionnaire was pretested at Tom Waddell Clinic. Revisions are currently being made based on the pretested version and the final questionnaire will be distributed at the next Planning Council meeting. A letter soliciting assistance in making the questionnaire available to clients will be sent this week to city agencies.

San Mateo County has been contacted regarding the questionnaire and is interested in distributing it; Marin County will also be invited to distribute this assessment tool.

VII. Continued Funding for HIV Infusion Services

Sophia Chang stated that the current contract with Visiting Nurses and Hospice (VN&H) and UCSF for Home Infusion Services, specifically targeting patients who receive infusion medications at SFGH, does not meet the current demand for services. DPH is augmenting this contract with funds now provided to the SFGH Pharmacy. Dr. Chang proposed that the Planning Council allow for a redistribution of FY 92-93 and FY 93-94 allocated funds from SFGH Pharmacy to the Home Infusion services contract at a rate of $700 per patient per month for seven additional patients. In 1992-93 this amount to $9,800, and in 1993-94 this amount to $58,800.

Stu Heard from SFGH Pharmacy reiterated the need for these home infusion services to be provided. He added that no patients who receive medications from the SFGH pharmacy would be adversely affected by this redistribution of funds.

Mike Shriver addressed his concern with the lack of Planning Council procedure around this type of transaction. Although he felt the service in question is definitely needed, he asked if all programs on the proposed CARE Title I Supplemental grant budget which did not receive funding should be considered for these funds.

Dr. Chang clarified the issue by stating these funds are not unexpended and, therefore, they must be viewed differently. These funds are already allocated and would be remaining within the same service type, pharmacy. This situation is not unlike a subcontractual agreement because DPH is involved through the MOU agreement, all changes must be brought before the Planning Council for approval. This proposed action is an attempt to utilize most efficiently the funds that have already been allocated for pharmaceutical services.

B. The following motion was passed by the Planning Council:
Abstentions: J.B. Molaghan

To approve the redistribution of funds from SFGH Pharmacy to Home Infusion Services for the amounts of $9,800 in FY 92-93 and $58,800 in FY 93-94.

VI. Probationary Process/70% Compliance Rule

Judith Weld distributed the revised Probationary Process. It was suggested that a definitions section be added for clarity and that a flow chart be made available to allow for easier understanding of the process. Ms. Weld will make the changes and redistribute the document for final approval.

Ms. Weld also distributed and discussed the policy on Compliance with CARE 70% Rule. Discussion followed on the Planning Council's motivations for creating this policy. The rule is an attempt to prevent the development of agencies that are overly dependent on CARE dollars and to facilitate a diverse revenue stream for agencies providing HIV services. CARE funding is provided on an emergency basis and may eventually wane.

The addition of donated staff time provided by a fiscal agent was made under, What May Be Counted In An Agencies Remaining 30% Revenue. (please see attached for revised copy)

C. The following motion was passed by the Planning Council :
Rita Times opposed.

To approve the policy Compliance with CARE 70% Rule with the noted changes.

VII. Unallocated Funds

Supplemental funds originally designated for the $1.8 mil DPH Detox Unit were allocated to programs assigned lower priority on the proposed CARE Title I grant budget to insure CARE funds are spent on time. This process was enacted with approval from the Planning Council and DPH with the assumption that there would be supplemental funds to the Supplemental budget from the Economic Stimulus Package. After funding the programs of lower priority, there are $618,132 remaining in unallocated funds. San Francisco is also eligible to apply for $746,299 in Title II funds.

Dr. Chang has asked DPH to update the AIDS Office on the status of the Detox Unit and to communicate any other priorities that DPH may have for these moneys for Planning Council consideration. She also suggested the possibility of allocating funds to programs that are in existence but whose applications were not approved for funding in the RFP process. Another possible solution is to poll contractors on current unmet needs and create one-time funding.

It was decided after discussion on how to allocate these funds, that the AIDS Office will gather information on the current Detox Unit status and on existing programs which were not approved in the RFP process for a report at the May 10, 1993 Planning Council meeting.

VIII. Public Testimony

Steve Lew, currently on leave from the Planning Council, announced that Team II at Health Center I is being dismantled. This team is the only component that provides mental health services to Gays and Lesbians and Asian Pacific Islanders. He encourages the Planning Council to take action by calling those persons listed at the bottom of the MENTAL HEALTH ALERT! (see attached).

POLICY ON COMPLIANCE WITH CARE 70% RULE
For CARE Funded Health Services Programs Operated by Community Based Organizations
Approved May 3, 1993
(italics indicate new procedures)

DOCUMENTS DEP
MAY 10 1993
SAN FRANCISCO
PUBLIC LIBRARY

I. Introduction:

In January 1991, the HIV Health Services Planning Council established a rule that CARE funding may account for no more than 70% of the service providing agency's total organization budget. This rule was developed as part of the first CARE letter of application (RFP) process. The original purpose of the rule was to prevent the development of agencies that were overly dependent on CARE dollars. Given that CARE funding is provided on an emergency basis, it may eventually wane. Enforcement is intended to ensure that agencies serving persons with AIDS will have a diversified revenue stream and be able to continue to provide services should CARE funds be reduced. This rule was reaffirmed by the Planning Council in October 1992.

II. Compliance and Enforcement:

Compliance with and enforcement of the 70% rule should occur *at three points* in interactions between a service provider and the AIDS Office, as follows*:

1. Application Process. Compliance with the 70% rule is an eligibility requirement of all CARE RFPs. (This eligibility criterion is distinct from the review criteria focusing on efficient use of other revenues, which examines the diversity of revenues in the agency and program budget.) An agency's budgeted revenue (projected revenue) is included in an application for new or rebid services. An agency's application is disqualified if compliance is not evident from the information provided in designated areas of the application budget forms. The RFP has also requested a letter of authorization from the Board of Directors. *In the future this letter signed by the Board should include statements of assurance that the agency complies with all three eligibility criteria, including the 70% rule.*

   In the past, the review and determination of disqualification has been made by an initial screening team consisting of the RFP Coordinator, HIV Services Coordinator, and Health Services Program staff. All disqualifications have been confirmed by the Health Services Branch Chief, Fiscal Services Branch Chief, and/or the Associate Director. *The Planning Council has suggested that one or more Council members should also participate in these review and disqualification determinations.*

   At this stage, compliance is determined by comparing the full amount of CARE money requested plus all other CARE funds received against the agency's total annual budget for either their current or upcoming fiscal year.

2. Monitoring Process. A budget report demonstrating actual revenue and expenses by funding source, as compared to budgeted revenue and expenses year-to-date, should be submitted to the AIDS Office for review as part of documentation required for a CARE monitoring visit. The report must have been reviewed and approved by the agency's Board of Directors prior to submission. *This report would be a new requirement in the monitoring process.* The AIDS Office will develop a format for this budget report.

*** Note:** Hospitals are required to follow JCAHO budgeting practices, as well as OSHPAD and third party payor accounting requirements. In addition, hospitals utilize cost accounting rather than fund accounting. Therefore, compliance and enforcement procedures may have to be adapted slightly in steps 2 and 3.

III. Actions, continued

3. Further actions which could be taken by the Planning Council include a reduction of CARE funds or delays in payment until compliance is achieved. (See the Probationary Process for CARE-Funded Health Services Programs for detail.)

4. The final action which could be taken by the Planning Council for lack of compliance could be the eventual defunding of the agency. (See the Probationary Process for CARE-Funded Health Services Programs for detail.)

IV. What May Be Counted in An Agency's Remaining 30% Revenue:

Agencies should discuss with their auditors what are auditable revenues source for a specific program. All items may initially be estimated, but must be verifiable and eventually documented. A plan may need to be developed for a documentation system for some components of the remaining 30%. *Revenue sources which may be counted in an agency's remaining 30% include the following, as long as each is auditable.*

MAY BE COUNTED

DPH contracts:
- General Fund
- Federal (Non-CARE)
- State

Federal grants, contracts, agreements (Non-CARE)
State grants, contracts
Local grants, contracts (includes other City contracts and subcontracts with other providers)
Foundation & corporation grants
Private donations, bequests
Medi-Cal reimbursement
Other 3rd Party reimbursement
Client copayment
In-kind donations valued and posted to agency ledgers:
- goods (e.g., drugs, medical supplies)
- services (e.g., pro bono audit, legal & accounting services, administrative support from fiscal agent)
- equipment (e.g., computer equipment, software)
- volunteer time (only if appropriate salaries are attributed*)

Components of a program which may not be counted toward an agency's remaining 30% include services provided by DPH or other agencies that are cooperative or collaborative efforts, or in-kind support or other revenue which is not auditable.

MAY NOT BE COUNTED

DPH cooperative efforts
In-kind support or other revenue which is not auditable
Cooperative efforts with other agencies (e.g., outstationed staff of another agency)
*Any volunteer hours of work donated by a paid employee may not be counted towards the 30%

REVISED DRAFT
SUBCOMMITTEE ON EVALUATION

Probationary Process for CARE-Funded Health Services Programs
Operated by Community Based Organizations or the Department of Public Health
May 5, 1993

DOCUMENTS DEP
MAY 10 1993
SAN FRANCISCO
PUBLIC LIBRARY

I. Introduction

All Department of Public Health contractors are required to provide services and to operate as specified by the terms of the contract exhibit(s), budget, and boilerplate agreement. All CARE contractors receive at least an annual contract monitoring which evaluates compliance with the terms of the contract, service delivery, standard of care, and general operating practices. This probationary process is intended as corrective action which would occur only after other, routine measures have failed, and/or when the instances of non-compliance are substantial and affect service delivery.

II. Definitions

"Agency"

The Community Based Organization contracted to provide services (includes both the service provider and the fiscal agent).

The Department of Public Health Division with a Memorandum of Understanding to provide CARE funded services.

"Contract"

The certified agreement between the Department of Public Health and the agency.

The final Memorandum of Understanding between the DPH AIDS Office and another DPH Division.

"Executive Director"

Beginning with step 5, this refers to the Executive Director of both the service providing agency and the fiscal agent.

This refers to the DPH program administrator responsible for execution of the MOU.

Board President

Beginning with step 5 this refers to the Board President of the fiscal agent, as well as the Board President of the service providing agency, if applicable.

This refers to the DPH Division Director.

III. Procedure

1. After a formal site visit, a service provider receives a monitoring report which includes: (a) a programmatic review and an agency-wide administrative/fiscal review for each specific program operated by the CBO; or (b) only a programmatic review for each specific program operated by a division of DPH. The report provides review team recommendations, which include commendations as well as recommendations and timelines. The service provider/fiscal agent is given a minimum of ten working days to return the signed monitoring report to: (a) endorse the findings; (b) add additional information, or explain extenuating circumstances; or (c) disagree with the findings.

2. The Health Services Branch of the AIDS Office includes a letter with the monitoring report, offering an opportunity for an agency Executive Director and appropriate staff to meet with the Program Manager and the Planning Council representative from the program's review team to discuss the monitoring report findings, interventions and timelines. Scores cannot be changed, except to reflect corrections made to factually inaccurate information. However, timelines can be extended.

3. Based on the original monitoring report findings and recommendations, or later problems with contract compliance, the AIDS Office may recommend that a program either: (a) be placed on probation, or (b) be defunded, with specific justifications for the recommendation. If probation is recommended, the AIDS Office must specify length of time for this action.

   Probation would be recommended for: failure to comply with contractual requirements (e.g., generally accepted accounting practices); failure to comply with specified policies and procedures; or failure to comply with performance requirements (e.g., provision of less than 50% of units of service or unduplicated clients). Probation might also include placing the contractor in receivership. Receivership includes assigning a DPH representative to be physically present for selected hours at the contracting agency during the probationary period. This representative reviews and approves all line item expenditures related to City contracts, reviews and approves all contract payment invoices submitted to the AIDS Office, reviews all personnel time reports for staff funded through contracts, reviews monthly bank statements on all accounts, and reviews personnel actions to be sure that they are consistent with Board policy and procedure (includes hiring and termination).

   It should also be noted that earlier interventions are available. The AIDS Office Fiscal Policies and Procedures (see attached) outlines: (a) accounting and invoicing procedures, and (b) contract performance requirements (e.g., provision of less than 90% and 75% of units of service or unduplicated clients, and steps that will be taken to bring a program into compliance with these procedures and requirements). Per the terms of a City contract, the City may withold any and all payments to a CBO until reports and/or requirements are received from the contractor and approved by the City. (Please see attached.)

   Defunding can be recommended because of: gross infractions of federal, state, or local law (e.g., fraud); failure to address mandated interventions and timelines required during a probationary period; continued failure to comply with performance requirements; because an agency is determined to be poorly governed (e.g., insufficient oversight by the board of Directors or by the staff appointed by the Board); or because a service is determined not to be needed. Defunding may take any one of three forms, depending on the reason for defunding:

3.
Defunding, continued

a. 30 day termination notice, with a plan to transition clients to another provider;

b. Termination at the end of the regular contract period without re-bidding or transitioning services. This would usually occur because services are no longer needed. Defunding for this reason could also be done by 30 day termination notice.

c. Termination at the end of a regular contract period, with a plan to transition clients to another provider.

4. During a probationary period, the service provider/fiscal agent has the opportunity to address all mandated interventions and timelines included in a monitoring report. However, a probationary process for a program could be concluded and defunding recommended at any time if one or more of the following are determined to have occurred: (a) a gross infraction of the law; (b) significant inability of the Board of Directors to manage the organization; or (c) significant inability of the organization's staff to deliver services or manage day to day operations.

5. Recommendations for probation or defunding, if based on a monitoring visit, are included in the monitoring report for the specific program. If developed separately from the monitoring visit, they will be incorporated into a letter to the Planning Council and amended to the monitoring report. A letter with these recommendations will also be sent to the agency Executive Director and Board President, who will have a minimum of ten working days to respond (before the recommendation is presented to the Subcommitee on Evaluation - see Step #7).

6. A recommendation for a probationary period for a specific program originates from the AIDS Office, the Planning Council, or the monitoring team, and is presented to the Planning Council for endorsement.

7. A recommendation for defunding a specific program can originate from: (a) the monitoring review team, (b) the AIDS Office, (c) the Planning Council, or (d) the Health Commission. Presentation of a defunding recommendation to the Planning Council from the monitoring review team or the AIDS Office will occurr via its Subcommittee on Evaluation.

8. Five working days prior to the Planning Council's consideration of the defunding recommendation, the agency's Executive Director and Board President are notified of the specific reasons for the consideration by the AIDS Office's Associate Director of Administration. The agency can present testimony in its own behalf.

9. The acceptance or rejection of a recommendation to defund a specific program is a decision of the Planning Council. A sole exception is a defunding recommendation originating from the Health Commission, which can be acted on unilaterally and without Planning Council approval. The Health Commission can also refuse to approve a contract presented for their review.

10. Within 3 working days of the Planning Council's decision to defund a program, the agency's Executive Director and Board President* will be notified by certified letter. This letter will include the specific jusifications for a defunding. If the decision is to defund immediately, the letter may provide a minimum of 30 days notice of contract termination. 30 days termination notice may also occur later, in order to allow time to develop a transition plan for clients.

11. Within five working days following the receipt of written notification, the agency may make a written appeal to the Planning Council's Subcommittee on Evaluation. Appeals must be signed by the fiscal agent's Board President. Appeals must be based on either: a) violation of the process outlined in this document; b) disagreement with the justifications originally presented for defunding.

12. Within five working days of receipt of a written appeal, the Subcommittee will examine the defunding decision. This meeting is open to the public, but the Subcommittee may discuss in private any information presented. Theagency's** Executive Director and Board President* are notified of date, time and place of the meeting by the AIDS Office Program Manager so that the service provider can present testimony on its own behalf. All decisions must be made in the public portion of the meeting.

    a. The Subcommittee may request the AIDS Office Program Manager and monitoring team members to review the history behind and the reasons for the defunding recommendation.

    b. The Subcommittee's review focuses on the service provider/fiscal agent's grounds for the appeal of the Planning Council's defunding decision.

13. Within three working days, the service provider's Executive Director and Board President are notified by certified letter of the Subcommittee's decision and reasons for either: (1) denying the appeal and upholding the defunding decision, (2) accepting the appeal and recommending that the Planning Council rescind the defunding decision, or (3) recommending that the program be monitored again within a specific period of time (i.e., put or maintained on probation).

14. The decision and reasons of the Subcommittee on Evaluation are final. If the appeal is denied and the defunding decision is upheld, then no further action is required by the Planning Council. If the appeal is accepted, then the Planning Council would need to consider endorsing this decision (i.e., accept the recommendation to rescind the defunding decision).

15. Once a decision to defund a program has been either: (a) upheld by the Planning Council, or (b) made by the Health Commission, termination of the program begins. The City may terminate the contract for the program by giving 30 days' written notice of the intent to terminate.

16. The AIDS Office begins a transition of contractual services to another provider immediately upon issuance of the 30 day notice.

Subcommittee on Evaluation (as of 5/3/93): Mary Jane Wood, Yvonne Frazier, and Karen Hembry. Laura Thomas will replace one of these members in case of a conflict of interest or lack of availability. Jon Dean Green will staff this body.

t\subcom (o\rfps\monitor)

TO THE LESBIAN AND GAY COMMUNITY

DOCUMENTS DEPT.
MAY 10 1993
SAN FRANCISCO
PUBLIC LIBRARY

MENTAL HEALTH ALERT!

The Department of Public Health's Division of Mental Health is in the process of dismantling vital mental health services for Lesbians and Gays in San Francisco. By June 30, 1993, at least five Gay Specialist positions will be eliminated from the mental health budget. Some of these Lesbian and Gay staff will be given other assignments not directly serving our community. Others will be "bumped" out of jobs or will resign. The result of this will be that outpatient mental health services for uninsured and poor Lesbians and Gays will be practically nonexistent in the city mental health system.

Team II, the outpatient clinic of dedicated and highly trained mental health workers at Health Center #1 in the Castro Neighborhood, will be decimated. The mental health services on which patients and staff of Public Health Center #1 have come to depend in the last fourteen years will be wiped out and a highly respected training program for new therapists specializing in Lesbian and Gay mental health treatment will be eliminated. Also, counseling and support services for the HIV Gay Asian/Pacific Islander Community will end.

It is especially vital now to continue these services because of the growing number of HIV patients who are getting their care at Health Center #1. These patients are poor, mostly uninsured, and frequently unemployed; they are not able to get the services they need elsewhere.

These cuts are creating a policy of de facto discrimination against Lesbian and Gay staff and patients in that a highly disproportionate percent of Lesbian and Gay health specialist positions will be eliminated and a highly disproportionate percent of Lesbian and Gay patients will be terminated from mental health treatment. Statistically, these cuts translate into a 50% reduction in outpatient mental health services.

ARE OTHER PROGRAMS IN THE MENTAL HEALTH SYSTEM BEING REDUCED EQUALLY? ABSOLUTELY NOT!

The community should not stand for this. Contact all of the following to demand that Lesbian and Gay outpatient mental health services be restored:

Dr. Raymond Baxter, Director of Public Health	554-2500
Jeffrey Jue, Director of Mental Health	255-3400
Carole Migden, Supervisor	554-4033
Roberta Actenberg, Supervisor	554-5556
Members of the SF Health Commission	554-2666
MAYOR JORDON	554-6141

A C T I M M E D I A T E L Y -- CUTS TAKE PLACE JUNE 30, 1993

F
22
1
10/93

HIV HEALTH SERVICES PLANNING COUNCIL

MAY 10, 1993
Douglass Elementary School
4235 19th Street at Collingwood
Time: 4:30 - 7:30

TENTATATIVE AGENDA

DOCUMENTS DEPT.
MAY 10 1993
SAN FRANCISCO
PUBLIC LIBRARY

I. Roll Call

II. Review of Minutes and Agenda

III. General Announcements

IV. Probationary Process

V. People of Color Subcommittee

VI. Update on A.I.D.S. and Shanti Project

VII. Distribution of Final Client-Based Needs Assessment

VIII. Regional Plan

IX. Public Comment

AIDS OFFICE
25 VAN NESS AVENUE, SUITE 500
SAN FRANCISCO, CA 94102 - 6033
415 - 554-9000
FAX 415 - 431-7547

HIV HEALTH SERVICES PLANNING COUNCIL

May 10, 1993

The Minutes of this meeting are missing.

San Francisco Public Library
Government Information Center

City and County of San Francisco

Department of Public Health

HIV Health Services Planning Council

DOCUMENTS DEPT.
MAY 7 1993
SAN FRANCISCO
PUBLIC LIBRARY

NOTICE OF MEETING

May 5, 1993

To: All Potential Contractors

From: Judith Weld, RFP Coordinator

Re: Community Input Meeting:
Prevention and Education Consolidated Services

The AIDS Office invites you to attend a Community Input Meeting on Thursday, May 20, 1993, to discuss services which may be solicited in an upcoming Request for Proposals.

The proposed RFP will solicit Prevention and Education services targeting high risk populations in San Francisco (such as men who have sex with men, injection drug users, other substance users, and sex partners of these high risk individuals). This RFP will cover services currently provided under multiple contracts and will emphasize consolidation and collaboration in service provision. If you have experience with these services or with these populations, we encourage you to attend this meeting. Your input about needs or concerns which exist in these communities will help us to write a more comprehensive RFP.

Date:	Thursday, May 20, 1993
Time:	12:00 noon - 2:00 p.m.
Location:	AIDS Office 25 Van Ness Avenue, 5th Floor San Francisco, CA 94102

If you have any questions about this meeting, please feel free to contact me at (415) 554-9044.

cc: Mitch Katz, M.D.
James Loyce, Jr.
Valerie Kegebein
Prevention Branch Program Managers
Galen Leung

o\rfps\correspo\prvcmty

DOCUMENTS DEPT.
MAY 21 1993
SAN FRANCISCO
PUBLIC LIBRARY

SF
#22
#1
5-24-93

HIV HEALTH SERVICES PLANNING COUNCIL
May 24, 1993
25 Van Ness, Third Floor Conference Room
4:30-7:30 p.m.

Tentative Agenda

I. Roll Call

II. Review of Minutes and Agenda

III. General Announcements

IV. Review of Planning Council Attendance

V DPH Equipment Requests for Unexpended Y02 Funds

VI. Unallocated Funds (Titles I & II)

VII. AIDS Office Recommendations re Shanti Programs

VIII. AIDS Office Update re A.I.D.S. Programs

IX. Public Comment

05193gaa

S.F. Dept. of Public Health
AIDS Office, Health Services Branch
25 Van Ness Ave., Suite 500
San Francisco, CA 94102-6033

San Francisco Main Library
Gov't Documentation Section
Larkin/McAllister Streets
San Francisco, CA

HIV HEALTH SERVICES PLANNING COUNCIL

May 24, 1993

The Minutes of this meeting are missing.

San Francisco Public Library
Government Information Center

DOCUMENTS DEPT.
JUN 10 1993
SAN FRANCISCO
PUBLIC LIBRARY

HIV HEALTH SERVICES PLANNING COUNCIL

June 14, 1993
25 Van Ness, Third Floor Conference Room
4:30-7:30 p.m.

Agenda

I. Roll Call

II. Review of Agenda and Minutes

III. General Announcements

IV. Castlerock Presentation on Medi-Cal Reimbursement

V. Housing Services Planning Update
Transition of Shanti Housing Programs

VI. Review of Planning Council Attendance

VII. Presentation of Planning Council Calendar of Meetings and Timelines

VIII. Analysis of Y03 CARE Title I and II Funding

IX. Presentation of Seroprevalence Data

X. Housing Needs Assessment

XI. AIDS Office Recommendations re A.I.D.S. Programs

XII. Public Comment

0x033gaa

AIDS OFFICE
25 VAN NESS AVENUE, SUITE 500
SAN FRANCISCO, CA 94102 - 6033
415 - 554-9000
FAX 415 - 431-7547

DOCUMENTS DEPT.
JUL 0 9 1993
SAN FRANCISCO
PUBLIC LIBRARY

HIV HEALTH SERVICES PLANNING COUNCIL
June 14, 1993
25 Van Ness, Third Floor Conference Room
4:30-7:30 p.m.

MINUTES

Members Present: Sandra Hernandez, Pat Christen, Barbara Garcia, Estela Garcia, Jaime Geaga, Gerald Lenoir, Gifford Leoung, Steve Lew, Kent Macdonald, Scott Miller, J.B. Molaghan, Bob Nelson, Steve Roger, Mike Shriver, Rita Times, Jerry Windley

Members Absent: Reggie Williams, Marcy Fraser, Yvonne Frazier, Les Hanson, Susan Karp, Elliot Ramos, Mary Jane Wood

Staff Present: James Loyce, Sophia Chang, Bill Haskell, Valerie Dorr, Judith Weld, Jon Dean Green

I. Roll Call

Roll Call was taken as above.

II. Review of Minutes and Agenda

The minutes of the May 24, 1993 meeting were approved.

III. General Announcements

Michael Shriver stated that the proposed amount of new monies in the President's budget for CARE was less than expected. It was originally estimated that an additional $310 million would be proposed in the House of Representatives. Instead, the amount of new monies proposed was $200 million. Mr. Shriver stated that $227 million in additional funds were proposed for NIH and $45 million for the CDC prevention programs.

IV. Castlerock Presentation on Medi-Cal Reimbursement

Don Martin and Miles Amen from Castlerock presented information on the Medi-Cal reimbursement study.

(Refer to enclosed handout.)

Q-For persons in a managed care program, could they enroll in the Medi-Cal waiver program? A-It would depend on the scope of services offered by the managed care plan.

Q-Does the Medi-Cal waiver program cover undocumented persons? A-No.

Sandra Hernandez stated that the Medi-Cal waiver program has a low rate of enrollment due to its complex/restricted admission criteria. These criteria result from combined State and Federal requirements.

V. Housing Services Planning Update

Bill Haskell stated that a meeting was held on June 9th regarding an AIDS housing model. Mr. Haskell stated that the first community input meeting had been held. There are two questions being posed. The first is how to improve current services. The second is how to develop additional housing and overcome barriers to service delivery. The next meeting is scheduled for June 23, 1993 to review the goals for AIDS housing services. Mr. Haskell stated that goals include ways to improve client access to housing and to expand development capability.

Gerald Lenoir stated that the community meeting was very productive with a wide diversity of perspectives represented. It was a "brainstorming" session.

VI. Review of Planning Council Attendance

The review was deferred to the June 21, 1993 meeting.

VII. Presentation of Planning Council Calendar of Meetings and Timelines

The presentation was deferred to the June 21, 1993 meeting.

VIII. Analysis of Y03 CARE Title I and II Funding

The analysis was deferred to the June 21, 1993 meeting.

IX. Presentation of Seroprevalence Data

The presentation was deferred to an unspecified date in July.

X. Housing Needs Assessment

Bill Rumpf, from the San Francisco Redevelopment Agency (SFRA), stated that the SFRA would be conducting a housing needs assessment for HOPWA funds. (Refer to enclosed handout.) The SFRA's perspective is that San Francisco has a well established non-profit housing continuum and large number of providers. A number of the current providers have volunteered to distribute the survey. The data will provide perspective for housing needs in San Francisco.

Q-When will the data be presented to the Planning Council? A-The SFRA will have preliminary information by early September.

Q-Will the SFRA be surveying residents of the Ambassador Hotel? A-Yes.

XI. AIDS Office recommendations re A.I.D.S. Programs

James Loyce stated that A.I.D.S. had responded to the AIDS Office monitoring report. One concern raised by the agency was the OMB A-133 audit required for 1991-92 monies. After consultation with A.I.D.S., this requirement was dropped. Mr. Loyce referred the Planning Council to the summary of compliance with CARE monitoring recommendations. The CARE monitoring took place in October,

1992. (Refer to enclosed handout.) Of the 26 distinct recommendations made for the 6 CARE funded programs, only one has been met. Some of the CARE monitoring recommendations are the same as those in the audit report. Mr. Loyce stated that the recommendation from the AIDS Office was for A.I.D.S. to be placed on probation for six months from June 14 through December 14, 1993.

Q-What type of follow up will be performed by the AIDS Office? A-The AIDS Office and the Board of Directors of A.I.D.S. will keep the Planning Council updated.

Q-Will the AIDS Office provide technical assistance? A-To the extent that AIDS Office staff have skills and adequate staffing to provide the needed technical assistance, assistance will be provided. A.I.D.S. is currently working with the Support Center.

Q-Is the recommendation of a six month probationary period acceptable to A.I.D.S.' Board of Directors? A-(Tom Gwyn) Yes. Mr. Gwyn added that he felt the audit report did not examine the agency in the context in which it works.

A) The following motion was passed by the Planning Council:

> To accept the AIDS Office recommendation of placing A.I.D.S. on probation for six months (June 14, 1993 - December 14, 1993).

Tom Gwyn asked the Planning Council to reconsider its decision to the Residence Program contract from A.I.D.S. Mr. Gwyn stated that the move was short sighted and would leave clients at A.I.D.S. without comprehensive services. Mr. Gwyn stated that the Health Commission was unable to provide him with minutes documenting its decision to remove the Residence Program from A.I.D.S. Mr. Gwyn asked who will follow up on clients? Mr. Gwyn stated that A.I.D.S. has a fair but firm program for repayee services.

Bobbie Thomson, A.I..D.S., stated that she had received a fax from the Social Security offices stating that the necessary paperwork to switch payee services had not been received. Kandyce Collins responded that clients must choose to go to Catalano and initiate the paperwork themselves. There will be a two month interval (July and August) for clients to initiate the paperwork necessary for them to transfer to Catalano.

Q-A.I.D.S. will continue to provide repayee services in July and August without recompense? A-The AIDS Office is working with the clients on-site to transfer them to Catalano. The clients will still continue to receive their checks at A.I.D.S. until clients initiate the proper paperwork.

Anne Welch, A.I.D.S., stated that she is a substance abuse counselor at A.I.D.S. and works with its accounting system. The system is a "one-write" system. She stated that she disagrees that the system is not auditable. Ms. Welch added that clients had received the flyers sent out regarding the transfer of services to Catalano. Some were unable to read the flyers; the majority were unwilling to go to Catalano.

Bruce Ocenia, A.I.D.S., stated he was a new member of the board of A.I.D.S. He stated the agency has the most organic links to clients with AIDS in the Tenderloin. He asked the Planning Council to reconsider its decision to remove the Residence Program.

Andrew Farley-- Mr. Farley stated he is a client at A.I.D.S. The clients at the Ambassador are very frustrated with the Planning Council. They do not understand who the Planning Council is, and why it has the power to take away their repayee services. Mr. Farley invited Planning Council members to come to the Ambassador and see how the clients live and the problems they face.

Q-Did the Health Commission vote to defund A.I.D.S.? A-Yes. (Jimmy Loyce) At the April 6, 1993 meeting, Mr. Loyce and Mitch Katz proposed to the Health Commission that the Residence Program be terminated pending completion of a transition plan for clients. Sandra Hernandez stated that there are no minutes to the consent calendar of the Health Commission to document the actions taken in the budget committee. The question asked of the AIDS Office bythe Health Commission at that meeting was why were all of A.I.D.S.' contracts not being terminated? The AIDS Office cogently explained why the Residence Program was the only program being recommended for termination, and asked the Health Commission to approve continuation of the other A.I.D.S. programs so that clients would continue to receive services. The Health Commission accepted the recommendation to terminate the Residence Program upon completion of a transition plan. Dr. Hernandez stated that if the Planning Council wished, the AIDS Office could return to the Health Commission for further changes.

Q-How many clients were being served under the residence contract? A-(Kandyce Collins) A.I.D.S. informed the AIDS Office it had 33 clients receiving Representative Repayee Services. The address list submitted to the AO by A.I.D.S. had 27 names, of which 20 are active clients.

In addition; the program was also providing information and r efferal and follow-upservices to non-repayee clients. The AIDS Office and A.I.D.S. were not in agreement on the focus of the Residence Program. The Planning Council also lacked consensus on whether members understood the original vote to defund the Residence Program to be related to repayee services only. To avoid subjective interpretations of the contract, the Planning Council requested the AIDS Office forward a copy of the contract to the members for future deliberation. The Planning Council had consensus in its understanding that while there would not be a break in service for repayee services, there would be a break in service for the remaining components in the contract.

The Planning Council was unable to reach consensus on the balance of funds remaining in the Residence Program contract. (The balance from $93,513, less ($13,522 allocated to Catalano) is $79,991) Council members were divided on whether the monies should be used for services at A.I.D.S. or be set aside for further deliberation. Bob Nelson spoke against A.I.D.S. retaining the monies. Mr. Nelson stated the monitoring reports were horrendous. Gerald Lenoir was in favor of A.I.D.S. retaining the monies. Mr. Lenoir stated that Planning Council members had not been aware that by defunding repayee, it was defunding the entire Residence Program. Pat Christen spoke against A.I.D.S. retaining the monies. Ms. Christen stated there was much more at stake than the remaining $79,991. San Francisco is being closely scrutinized by HRSA (the federal Health Resources & Services Administration). The CARE appropriation will in part depend upon how Congress views the oversight of the CARE funds spent to date. The audit report for A.I.D.S. was abominable. Ms. Christen stated that if the Planning Council can review this type of documentation and want to return monies to the agency, that is a problem. She also stated that the lack of accountability at the A.I.D.S. board of directors level was a problem. Steve Lew stated that unless the Planning Council had the ability to prevent a break in services to clients, there would be no immediate effect on clients. Mr. Lew stated the Planning Council should move on to addressing its own accountability.

The following motion was not passed by the Planning Council:

That the probation process go forward, with the monies not diverted to Catalano but staying with A.I.D.S.

Members of the Planning Council next asked if the monies were set aside, and the AIDS Office in conjunction with a subcommittee, sole sourced the service, what the timeline for a contract would be. Sophia Chang responded that for a contract to be in place it would take 4-6 months to bid the services, 2-3 months to sole source. Sandra Hernandez stated that as there are a number of agencies that can provide housing services, the more fair process would be to put the services to bid, while acknowledging the break in services.

The following motion was passed by the Planning Council with Jaime Geaga and J.B. Molaghan abstaining:

A) To set aside the $79,991 remaining from the A.I.D.S. Residency Program, with the AIDS Office and a Subcommittee of the Planning Council determining the appropriate services to be provided and identifying a provider of services which could include A.I.D.S.

James Loyce and Tom Gwyn assured the Planning Council that although there were differences between the AIDS Office and A.I.D.S, they can and do work well together. Mr. Loyce stated that the AIDS Office staff will work responsibly and effectively with A.I.D.S. and that he is sure that A.I.D.S. Board of Directors will work responsibly and effectively with the AIDS Office.

06213gaa

HIV/AIDS Housing Needs Assessment
Overview -- June 9, 1993

1. Goal

To determine the HIV/AIDS housing resources and services needs in San Francisco from a qualitative perspective. The assessment will serve to:

a. Identify the needs of all people with HIV/AIDS.
b. Evaluate the existing continuum of housing resources and services.
c. Develop a plan for addressing the future housing and housing services needs of people with HIV/AIDS.
d. Guide priorities for future funding and resource development.
e. Provide a framework for developing a 5-year plan to address the housing and housing services needs of all persons with HIV/AIDS throughout the continuum of care.

2. Potential Data Sources

The needs assessment will attempt to represent all perspectives and community consensus on HIV/AIDS housing needs in San Francisco. Input into the needs assessment will be sought through the following.

a. Clients Using ASO Services
- Review of current housing/residential services.
- Client survey/interview/focus groups.
- Review client satisfaction surveys.
- AIDS Office surveillance data (inc. case projections).
- Income data from AIDS Office quarterly reports.

b. ASO Program Staff and Monitoring Reports
- Survey/interview/focus groups of ASO housing providers.
- Review AIDS Office residential services monitoring and quarterly reports.
- Community meetings on the general model of housing services.
- Waitlists/needs/HOPWA and CARE system capacity.

c. People with HIV who are Not Using AIDS Housing
- Data from UCSF Homeless Project Survey.
- Survey/interview residents in non-AIDS-specific housing.

d. Housing Developers - Non-AIDS-Specific
- Interviews/survey of non-AIDS-specific housing providers.

e. Other Resources
- Housing Assessment Plans and Housing Program Models from other cities.
- Input from AIDS Housing Network, HIV Health Services Planning Council, Council of Community Housing Organizations, CHAS developers.
- Surveys conducted by other local groups (i.e. MHA).
- AIDS Office client needs assessment for health services (demographic and self-identified needs).

3. The Client Perspective

The Assessment will include a range of client perspectives, gained by working closely with many agencies to conduct surveys, interviews and focus groups of targeted samples. Within each segment, client needs will range from independent living, to assisted living, to supervised care, to custodial care, to terminal care.

Our sampling system will target the following client segments:

Asian/Pacific Islander	African American
Latino	Native American
Youth	Women
Women with kids	Disabled
Substance Abuse	Mental Illness
Substance/Mental Illness	SRO-non service users
Homeless	Clients with TB
Couples	Asymptomatic HIV+
Immigrants	White

4. Components of the Needs Assessment

The assessment will:

a. Review the current housing services, defining service categories.
b. Review findings from client and provider surveys, interviews and focus groups.
c. Describe current housing services' ability to meet client needs.
d. Identify and describe unmet or partially met needs.
e. Describe effectiveness of specific housing programs.

The recommendations will include:

a. Restructuring current housing system to meet identified needs.
b. Desired housing capacity, and capacity expansion if needed to meet identified needs.
c. Recommendations on funding priorities and which residential services (including ongoing operating expenses and supportive services) to support with HOPWA funds and which to support with CARE funds.
d. Ways to integrate persons with AIDS/HIV into existing (non-AIDS) housing resources.

5. Inventory of Existing Housing Resources

Define housing program types, using consistent terminology for these categories:

a. Emergency housing (subsidies, hotel vouchers, emergency rental assistance).
b. Transitional housing.
c. Independent living (i.e. centralized residences, decentralized shared apartments, SRO hotels).
d. Assisted living (similar settings with non-medical attendant care or IHSS.
e. Supervised care (board & care facilities).
f. Custodial care (i.e. 24-hour care houses).
g. Terminal care (residential hospice facilities).

6. Inventory of Financial Services

Describe eligibility criteria and expected funding for:
- HOPWA, CARE, and McKinney Act housing programs

7. Evaluation of Trends

Review the following trends: AIDS agencies (providing housing and supportive services), housing (including non-AIDS specific), HIV-prevalence, changes in HIV-care levels needed and funding resources.

8. Evaluation of Current Housing Policies/Plans

Assess how current systems comply with or are inconsistent with major policy plans (CHAS, other housing plans, HIV Planning Council, Health Commission, Board of Supervisors, and the Mayor's Office.)

9. Development of Action Plan

Short-term and long-term action steps including:
- goals, objectives, strategies
- funding scenarios
- policy change scenarios
- mechanisms for coordinating housing development and operation
- mechanisms for coordinating client access to housing resources and services.

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH AIDS OFFICE

Phase I Report

Medi-Cal Revenue Enhancement And Copayment Project

Presented To The Mayor's HIV Health Services Planning Council

June 14, 1993

CRCG
CASTLE ROCK CONSULTING GROUP

I. Project Overview

Project Purpose

Assure Community Based Organizations Are Maximizing Specific Revenues Through:

- Assessment Of Impact, Feasibility and Recommended Approach For Expanded CBO Medi-Cal Participation
- Analysis Of Potential Impacts Of A Client Copayment System

I. Project Overview

Project Purpose

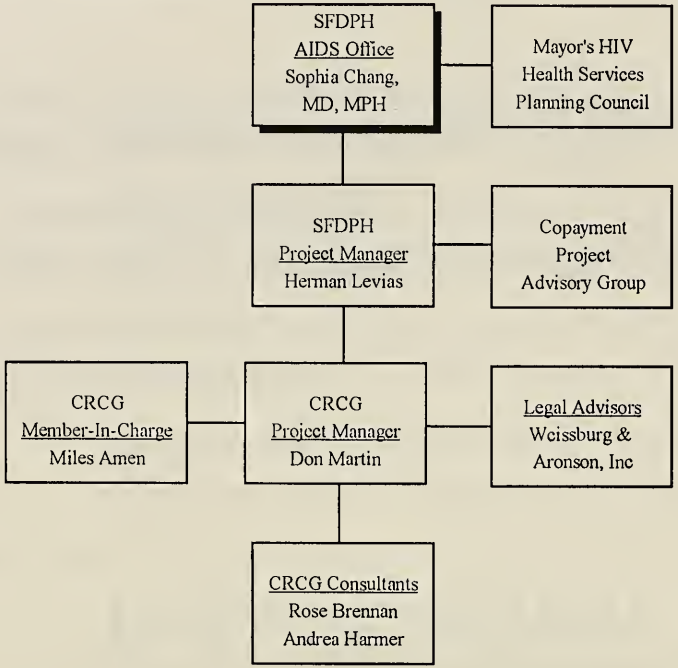
Assure Community Based Organizations Are Maximizing Specific Revenues Through:

- Assessment Of Impact, Feasibility and Recommended Approach For Expanded CBO Medi-Cal Participation
- Analysis Of Potential Impacts Of A Client Copayment System

Project Workplan

- Phase I - Research And Analysis Of Current CBO Environment and Medi-Cal Program
- Phase II - Research And Analysis Of Copayment System
- Phase III - Design Model Medi-Cal Revenue And Billing System
- Phase IV - Document Feasibility Of CBO Billing

Project Organization



CRCG
CASTLE ROCK CONSULTING GROUP

II. Medi-Cal Program Overview

Medi-Cal Health Services Program Overview

- Services Generally Recognized As Standard Medical Services Required In The Treatment Or Prevention Of Disease, Disability, Infirmity Or Impairment
- Available To Individuals Meeting Criteria For Income, Disability And Criticality Of Need
- Services Can Be Provided In Various Settings (e.g., Hospital, Clinic, Physician's Office, Home and Other Alternate Sites)
- Many Services Require Formal Authorization
- State's Plans To Incorporate Managed Care Model May Impact This Reimbursement Source

Examples Of Medi-Cal Health Reimbursable Services

- Hospitalization
- Outpatient Services Including
  - Primary Medical Care
  - Laboratory
  - Infusion Services
- Home Health Services
  - Nursing
  - Social Work
- Mental Health Service
- Pharmacy

Adult Day Health Care Program Overview

- Available To Medi-Cal Recipients Requiring Medical Or Rehabilitative Services To Maintain Present Level Of Functioning
- Administered By California Department Of Aging
- Services Provided Outside Of Institutional Setting
- Multi-Disciplinary Services Must Be Available
- HIV Care Model And Client Needs Differ Significantly From Typical Adult Day Health Care
- Services To Program Participants Must Be Authorized By Medi-Cal

Adult Day Health Care Reimbursable Services

- ADHC Providers Reimbursed On Per Diem Rate
- Licensure Requires That ADHC Programs Make Services Available From:
  - Physician And Physician Assistant
  - Nurse Practitioner
  - Clinical Psychologist
  - Clinical Social Worker
  - Allied Health Workers

Medi-Cal Waiver Program Overview

- Instituted In 1991 - Available To Medi-Cal Recipients With AIDS Or ARC Diagnosis And Karnofsky ≤ 60
- Total State-Wide Enrollment Cannot Exceed 2,200 Enrollees
- Yearly Payment Limited To $13,209 Per Enrollee
- Waiver Services May Only Be Provided In Non-Institutional Settings
- Clients Cannot Be Concurrently Enrolled In Multiple Waiver Organizations
- Waiver Organization Assumes Financial Responsibility

Medi-Cal Waiver
Reimbursable Services

- Nursing Case Management
- In Home Skilled Nursing
- Attendant Care
- Homemaker Care
- Psychosocial Counseling
- Foster Care Supplement
- Non-Emergency Medical Transportation
- Nutritional Counseling And Supplements
- Home Delivered Meals
- Administrative Expenses ≤ overhead directly related to POS, claims submission, nursing administrative support

Note: Services Must Be Provided By Specified Personnel

CRCG
CASTLE ROCK CONSULTING GROUP

III. Phase I Methodology

Phase I Objectives

- Determine Current Status Of CBO Participation In Medi-Cal Programs
- Identify Potential Opportunities For Increased Medi-Cal Reimbursement
- Identify Potential Impacts From Implementing A Medi-Cal Revenue Enhancement Program

Phase I Activities

- Gather Available CBO Provider Information
- Review Pertinent Medi-Cal Program Information
- Conduct Focused CBO Interviews
- Analyze Data
- Prepare Phase I Report

Gather CBO Provider Information

- Purpose
  - Assess Current Services And Identify Those Which May Be Reimbursable By Medi-Cal
- Sources Of Data
  - CBO 1992-1993 Contracts With AIDS Office
  - CBO Quarterly Reports

Review Medi-Cal Program Information

- Purpose
  - Develop General Understanding Of Program Requirements And Potential Benefits To HIV Service Providers
- Sources Of Data
  - Medi-Cal Health Services Documentation
  - Medi-Cal Waiver Services Documentation
  - Adult Day Health Care Documentation
  - Discussions With California Department Of Health Services Representatives
  - Medicaid Administration (SB910) Documentation - See Appendix I

Focused CBO Interviews

- Purpose
  - Evaluate Current Medi-Cal Billing Status
  - Examine Reasons For Not Seeking Medi-Cal Reimbursement
  - Assess Organization's Infrastructure
- CBO Selection Criteria
  - Organizations Currently Billing Medi-Cal
  - Organizations Not Billing Medi-Cal
- Final Selection Of Interview Participants Approved By AIDS Office (See Appendix II)

Data Analysis

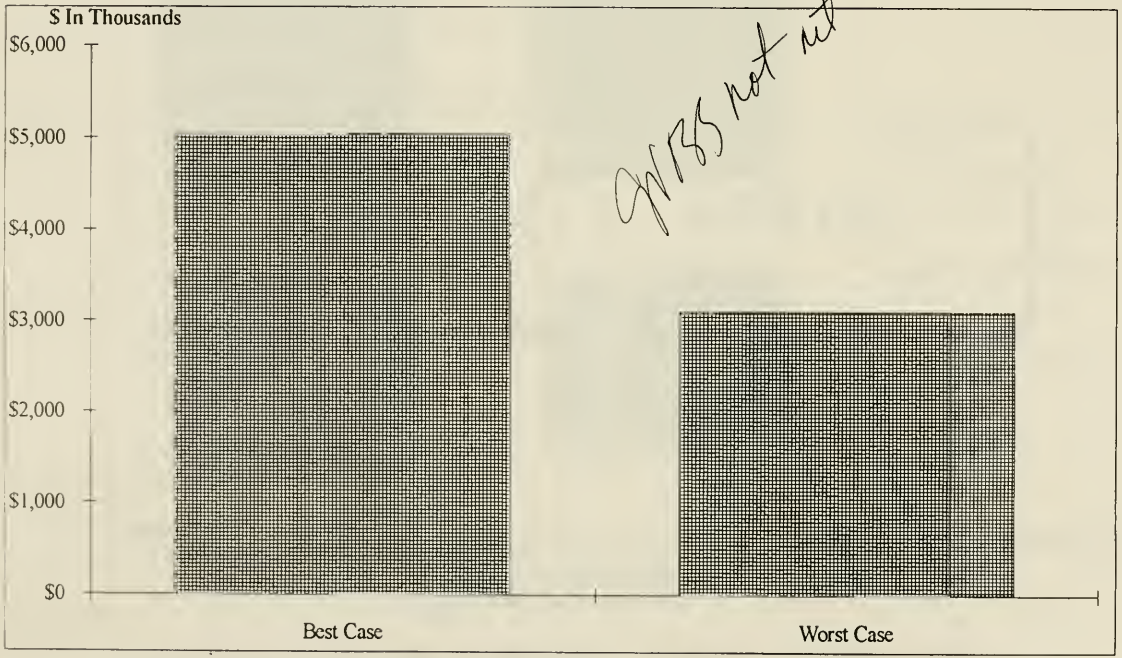
- Purpose
  - Assess Preliminary Financial Implications And Organizational Impacts
- Approach
  - Reviewed Available Materials
  - Used Standard Database and Spreadsheet Software
  - Assured Reasonable Data Quality
  - Performed Aggregation And Consolidation
  - Conducted Data Modeling Activities

IV. Financial Assessment

Incremental Medi-Cal Revenue Potential

- Clinical Interventions
  - Majority Of HIV Contracted Programs That Provide Clinical Interventions Which Are Medi-Cal Reimbursable Appear To Be Maximizing Medi-Cal Revenue
  - Minimal Potential Appears To Exist For Incremental Medi-Cal Revenue
- Adult Day Health Care
  - Single Provider Currently Working With Medi-Cal To Maximize Reimbursement
  - Actual Collections In Current Contract Year May Be Significantly Less Than Budget
  - Potential For Additional Revenue Appears To Exist Only If Client Volume Increases
- Waiver Program
  - Approximately 20 Organizations Provide Waiver Services
  - Significant Potential Exists To Increase Medi-Cal Reimbursement Under Medi-Cal Waiver Program

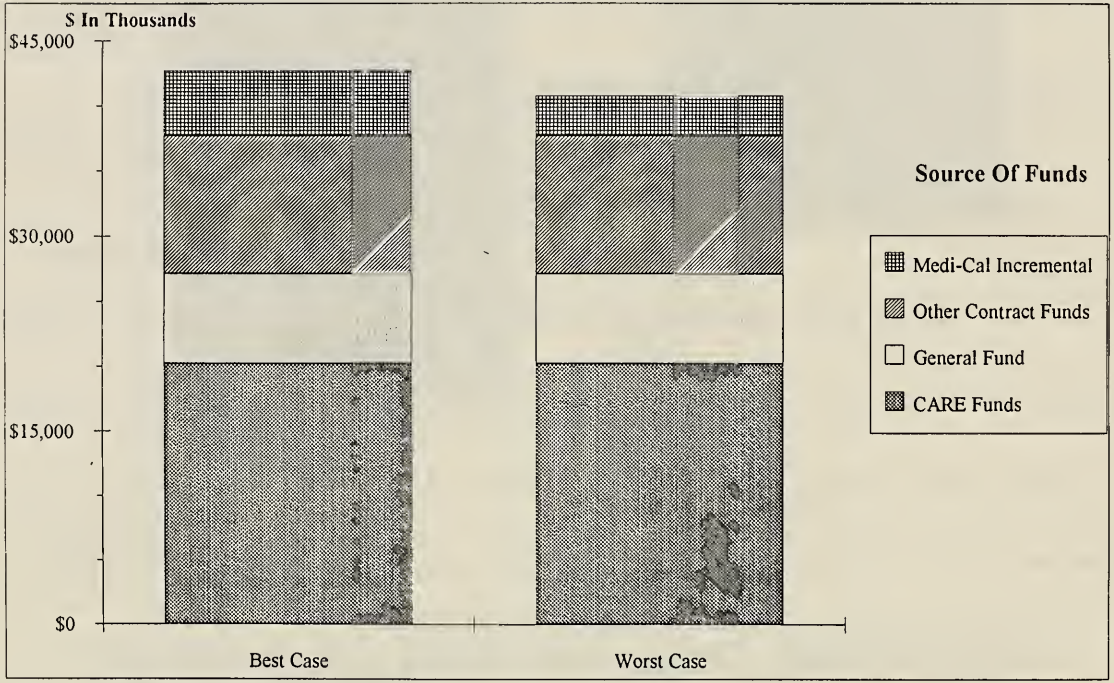
Medi-Cal Incremental Revenue



Source: SF AIDS Office Contracts and CRCG Analysis

CRCG
CASTLE ROCK CONSULTING GROUP

Impact Of Medi-Cal Waiver Revenue



Source: SF AIDS Office Contracts and CRCG Analysis

CRCG
CASTLE ROCK CONSULTING GROUP

Appendix I - SB910

SB910 Medicaid Administration Overview

- Provides Increased Federal Reimbursement For Health Related Administrative Activities, Not Direct Client Services
- Reimbursement Determined By Allocating Appropriate Portion Of Organization's Costs For Applicable Activities
- Quarterly Time Studies Are Conducted To Establish Basis For Payment
- Possible Significant Additional Revenue May Be Available From This Source
- Focused Effort May Be Appropriate To Assess Applicability And Feasibility

SB910 Medicaid Administration Activities

- Eligibility Determination
- Outreach For MediCal Eligibles
- Case Planning And Coordination
- Client Assistance To Access Services
- Interagency Coordination
- Training
- General Administration
- Utilization Review

Appendix II - CBO Interviewees

CBO Interviewees

On-site Interviews:

- **American Indian AIDS Institute**
  - → Thomas Lee Eades, Administrator/Education
  - → Debra Rodriguez, Case Manager
- **Black Coalition On AIDS**
  - → Scott Baoderson, Operations Manager
  - → John Patten, Substance Abuse Counselor
  - → Joy Rucker, Project Manager/Rafiki House
- **Continuum HIV Day Services**
  - → Mark Arseneau, Program Director
  - → Susan DeGrande, Fiscal Manager
  - → Karen Weiss, Public Policy Specialist
- **CPMC - Visiting Nurses & Hospice**
  - → Robin Candace, Intake Coordinator
  - → Art Gunner, Billing Manager
  - → Mary Ann Kachur, Patient Care Supervisor
  - → Heidi O'Connor, Director Of Business Development

Interviewees (Con'td)

- **GAPA Community HIV Project**
  - → James Lee, Financial Director
  - → Danny Yu, Support Services Director
- **Mission Neighborhood Health Center**
  - → Brenda Y. Storey, AIDS Services Coordinator
- **Native American Health Center**
  - → Darlene Petropoulos, Billing Supervisor
- **Rose Resnick Center For The Blind**
  - → Tom Gaughan, Program Coordinator/Case Manager
  - → Mave Metzger, Intake
  - → Gloria Young, Director
- **St. Mary's Hospital**
  - → Gloria Eberling, Patient Accounting
  - → Daniel Ostrow, Program Director
- **San Francisco AIDS Foundation**
  - → Ralph Jennings, Billing Director
  - → Carmen Madres, Intake
  - → Kenneth Shigematsu, Social Worker/Financial Benefits

Interviewees (Con'td)

- **SF Community Clinic Consortium**
  - → Sheila Cohen, Pulbic Policy Analyst
  - → Ted Knapp-Duncan, Director, HIV Programs
- **UOP Dental School**
  - → Charlene Pugh, Fiscal Director
  - → Diane Weiner, Patient Care

Telephone Interviews:

- **Catholic Charities**
  - → Sarah Gillies, Director Health Services
  - → Ruby Moran, Accounting
  - → Michael Vargus, Intake/Case Management
- **CPMC - Children's Hospital**
  - → Lisa DeAngeles, Billing
  - → Lutrelle Jolly, Social Worker/Counselor
  - → David Silven, Neuropsychologist
- **UCSF - AIDS Health Project**
  - → Joanna Rinaldi, Program Director

HIV HEALTH SERVICES PLANNING COUNCIL

June 21, 1993

The Agenda of this meeting is missing.

San Francisco Public Library
Government Information Center

DOCUMENTS DEPT.
JUL 0 9 1993
SAN FRANCISCO
PUBLIC LIBRARY

HIV HEALTH SERVICES PLANNING COUNCIL
June 21, 1993
25 Van Ness Ave., 5th Floor
4:30-7:00 p.m.

MINUTES

Members Present: Pat Christen, Yvonne Frazier, Barbara Garcia, Jaime Geaga, Les Hanson, Gerald Lenoir, Gifford Leoung, Steve Lew, Kent Macdonald, Bob Nelson, Elliot Ramos, Steve Roger, Rita Times, Jerry Windley, Mary Jane Wood

Members Absent: Sandra Hernandez, Reggie Williams, Marcy Fraser, Estela Garcia, Karen Hembry, Susan Karp, Scott Miller, J.B. Molaghan, Mike Shriver, Laura Thomas

Staff Present: Sophia Chang, Bill Haskell, Valerie Dorr, Galen Leung, Jon Dean Green

I. Roll Call

Roll Call was taken as above.

II. Review of Minutes and Agenda

The minutes of the June 14, 1993 meeting were not ready for approval. The agenda was approved.

III. General Announcements

Jon Dean Green announced that effective June 30, 1993 he would no longer be with the AIDS Office. Mr. Green stated that due to "bumping" within Civil Service, he will be displaced from his current position. He stated that he has accepted a position with the Contra Costa AIDS Office and will begin there in August.

IV. Update on the City Budget

Galen Leung stated that as of Friday, June 18th, the Mayor had announced a $14 million restoration to the Department of Public Health (DPH) budget. Of this, $2.5 million will be restored to Community Public Health Services(CPHS)/AIDS Office. The $1.7 million for CPHS will be used to restore Health Centers #2 and #4 and Potrero Hill. The remaining $800,000 will be used to restore cuts to the AIDS Office.

Mr. Leung stated that after analysis of the restoration of monies to DPH, it appears that the City will meet the CARE Act requirement regarding maintenance of effort. The City will exceed the dollar amount required under the maintenance of effort clause by ~$100,000.

Q-Must the Board of Supervisors approve the $14 million restoration? A-Yes. The Mayor has agreed to the restoration, so the assumption is that the monies will show on the Board proposal for the City budget.

Pat Christen stated that $100,000 was not a large amount of cushion for maintenance of effort. Ms. Christen stated her concern that the funds might be lost in another round of budget cuts. Jon Dean

Green stated that maintenance of effort was a snapshot in time. For Y03 monies, the snapshot was taken at the time of the Formula Application. The City certified at that time it was in compliance with maintenance of effort. It will not need to recertify its compliance again until the next Formula application.

Q-Are there further cuts expected upon passage of the State budget? A-No.

Q-In terms of bumping of DPH staff, what is the required time for notification? A-30 days. Due to the late nature of the current restorations, DPH will be sending out lay off notices that will subsequently be rescinded. [Later clarification by AO staff - there is no required notification to individuals being "bumped" from positions, as long as the position remains funded.]

Jerry Windley stated that the Mayor's Office has assumed a worst case scenario when preparing its budget. The budget assumed much larger cuts from the State than may occur. It appears that the loss of monies to the City if it approves continuation of the 1/2¢ sales tax in the November election will be markedly less than anticipated.

Q-What will be the extent of bumping in the AIDS Office? A-The AIDS Office is unsure of the overall effect bumping will have on the office. In certain classifications, bumping is citywide. This makes it more difficult to assess. The AIDS Office has attempted to place waivers on positions thought to be at risk. The Fiscal Services branch is most at risk as Civil Service will not place waivers on positions of that type.

Steve Lew stated that the Planning Council should weigh in on the issue of CARE funded positions. Many of the positions performing work in the community are ones requiring cultural competency and HIV sensitivity. Mr. Lew stated he is concerned about mental health and substance abuse programs. He would not like to see effective people lose their jobs to bumping.

Q-Can waivers be placed on positions at risk? A-No. The Mayor's Office has frozen waivers being placed on positions during the bumping process.

A) The following motion was passed by the Planning Council:

> That the Planning Council in its oversight role for CARE Titles I and II wants assurance from the City that positions funded with CARE monies will have those positions continue to be filled with persons who are HIV sensitive and culturally and linguistically competent.

The Planning Council requested the AIDS Office prepare a list of civil service positions funded under CARE, and the number and type of waivers on those positions.

V. Review of Planning Council Attendance

Jon Dean Green stated that letters regarding Planning Council attendance had been sent to all members whose terms began in January. The question Mr. Green asked was what would the Planning Council like to have occur next? Mary Jane Wood stated that it was a simple matter of whether or not the Planning Council was prepared to live by its bylaws.

B) The following motion was passed by the Planning Council:

To have the staff examine one-year attendance, persons who have attended less than 50% of the meetings from July 1992 through June 1993 will have to confirm their continued wish to take part on the Planning Council. No response will be deemed an effective resignation.

VI. Presentation of Planning Council Calendar of Meetings and Timelines

Jon Dean Green presented the timeline to Planning Council members for upcoming meetings for July through December, 1993. Mr. Green stated that the Planning Council should take special note of the October 11, 1993 (Columbus Day) meeting which is scheduled for reprioritization of services .

Jerry Windley reminded the Planning Council that not all members worked for AIDS Service Organizations. Columbus Day is a regularly scheduled work day. The Planning Council consensus was that the meeting should tentatively be set for 12:00 to 6:00 p.m.

Steve Lew stated that September looks especially busy and suggested the Planning Council move to weekly meetings. The Planning Council agreed and asked the AIDS Office to send out meeting dates and times.

Bill Haskell next reviewed the proposed rating system for Y03 CARE monitorings. (Refer to enclosed handout.) Mr. Haskell stated that a community input meeting had been held and the agencies present had expressed favorable opinions of the rating system.

Mr. Haskell stated that the new approach to scoring reflected input received from the community in the last round of monitorings. There are a 100 total points. Each category is weighted and can receive a score of 0-5. Valerie Dorr stated that the scores for Units of Service (UOS) and Unduplicated Clients (UDC) will be weighted so that the score will reflect any improvements in continuing programs. (Refer to enclosed handout.)

C) The following motion was approved by the Planning Council:

For new contracts in Fiscal Year 1992-93 to be weighted 40% for 92-93 performance and 60% performance for 93-94 performance as follows:

1st 6 mos 92/93 x 0.15 + 2nd 6 mos 92/93 x 0.25 + 1st period 93/94 x 0.6

D) The following motion was passed by the Planning Council:

To approve the rating categories and weights.

VII. Analysis of Y03 CARE Title I and II Funding

(Refer to enclosed handout.)

Jon Dean Green reviewed the enclosed handout. Gerald Lenoir stated that the overall goal for funding to People of Color agencies is short of the percentages set by the Planning Council for Y03. Mr. Lenoir stated that the Planning Council must consider whether the goal is unrealistic or whether not enough effort was put forward. The Planning Council asked the AIDS Office to supply it with percentages of services provided by People of Color agencies broken out by service category. It was also noted that the distributed list was incomplete; the AIDS Office will complete a more complete report for the next meeting.

VIII. Public Comment

There was no public comment.

06233gaa

Formula for Determining UOS/UDC Score

Contracts that were new contracts for Fiscal Year 92-93 will be weighted 40% for 92-93 performance and 60% for 93-94 performance as follows:

1st 6 mos 92/93 x 0.2 + 2nd 6 mos 92/93 x 0.2 + 1st period 93/94 x 0.6

Contracts that were renewal contracts for Fiscal Year 92-93 will be weighted 50% for 92-93 performance and 50% for 93-94 performance as follows:

1st 6 mos 92/93 x 0.25 + 2nd 6 mos 92/93 x 0.25 + 1st period 93/94 x 0.5

Y03 CARE Funding for POC By Service Type
(Based on POC Agencies and POC Targeted Programs)

FUNDS	AGENCY	SERVICE	AMOUNT
Primary Care			
F	A.I.D.S.	Mental Health/SA Srvces	$124,736
S	American Indian AIDS Institute	Crisis Intvntn/Mental Health	$26,125
S	Baker Places	Med. Term Res. Treat.	$228,015
F	GMOC/EACH	Com. Events/Indiv. Treat. Adv.	$163,804
S	Mission Neighborhood Hlth Ctr.	Treatment Advocacy	$27,820
S	Mission Neighborhood Hlth Ctr.	Clinical Trials Advocacy	$38,503
S	SF Clinic Consortium	Primary Medical	$218,405
F	SFGH Mjnority Outpatient Care	HIV-IDU Case Mgt	$109,931
S	UCSF Sub Abuse Tx @ SFGH	Sub. Abuse Treatment	$117,008
Housing			
F	A.I.D.S.	Housing Mgt./Case Mgt.	$170,451
S	Black Coaliton on AIDS	Transitional Housing	$248,196
S	**Haight Ashbury Free Clinics**	**Res. SA for Afr. Am. Women**	**$244,747**
S	Walden House	Long Term Res. Treatment	$233,325
F	Walden House	Sub. Abuse Treatment	$218,369
S	Westside	Residential Care AIDS/MH	$313,500
Case Management			
F	A.I.D.S.	Case Management	$179,423
F	American Indian AIDS Institute	Case Management	$35,490
F	GCHP	Case Management	$23,661
F	Instituto Familiar de la Raza	Psychosocial Support	$109,203
S	**SF Clinic Consortium**	**Clinical Case Management**	**$92,522**
II	**Tenderloin AIDS Network**	**Brokerage Case Mgt.**	**$64,779**
S	Westside	Nursing Case Management	$90,887
Psychosocial			
F	American Indian AIDS Institute	Case Mgt/Prac Support	$35,887
F	American Indian AIDS Institute	Practical/Emotional Sup.	$40,554
F	BAHSES-BWMT/MACT	Emotional Support	$97,375
S	Bayview Hunter's Point Foundation	Vol. Training/Emot & Practical Su	$107,239
F	Bar Association	Legal Service	$39,214
S	GCHP/FTFA	Client Advocacy	$81,902
II	**GCHP/FTFA**	**Client Advocacy/Volunteer**	**$66,662**
F	Filipino Task Force on AIDS	Translation Services	$26,125
F	TARC	Emotional Support	$74,454
Other Health Care			
S	Bayview Hunter's Point Foundation	Other Primary Care	$93,728
S	Mission Neighborhood Hlth Ctr.	Nutritional Counseling	$115,825
F	Westside	Minority Attendant Care	$100,466

TOTAL FUNDING	
Overall POC Contracts	$3,958,331
Overall Contractual Service	$20,252,991
Percentage of POC Funds	19.54%

pocsrvc

BOLD= New program in Y03

Y03 CARE Funding for POC

FUNDS	AGENCY	SERVICE	AMOUNT
Formula			
	A.I.D.S.	Mental Health/SA Srvces	$124,736
	A.I.D.S.	Housing Mgt./Case Mgt.	$170,451
	A.I.D.S.	Case Management	$179,423
	American Indian AIDS Institute	Case Management	$35,887
	American Indian AIDS Institute	Practical/Emotional Support	$40,554
	American Indian AIDS Institute	Case Mgt/Prac Support	$35,490
	BAHSES-BWMT/MACT	Emotional Support	$97,375
	Filipino Task Force on AIDS	Translation Services	$26,125
	GCHP	Case Management	$23,661
	GMOC/EACH	Com. Events/Indiv. Treat. Adv.	$163,804
	Instituto Familiar de la Raza	Psychosocial Support	$109,203
	TARC	Emotional Support	$74,454
	SFAF	Case Management	$76,897
	Prof. Mgt. Develop.	Primary Medical Care	$220,001
	Westside	Minority Attendant Caer	$100,466
	Total POC Contracts		$1,478,527
	Total Contractual Services		$5,498,970
	Percentage Of POC Funds		27%
Supplemental			
	American Indian AIDS Institute	Crisis Intvntn/Mental Health	$26,125
	Bayview Hunter's Point Foundation	Vol. Training/Emot & Practical Support	$107,239
	Bayview Hunter's Point Foundation	Other Primary Care	$93,728
	Black Coaliton on AIDS	Transitional Housing	$248,196
	GCHP/FTFA	**Client Advocacy/Volunteer**	**$66,662**
	Mission Neighborhood Hlth Ctr.	Treat& Clinical Trials Adv/ Nutr. Cnslin	$115,825
	TARC	**Brokerage Case Mgt.**	**$64,779**
	Westside	Nursing Case Management	$90,887
	Westside	Residential Care AIDS/MH	$313,500
	Total POC Contracts		$1,126,941
	Total Contractual Services		$12,202,331
	Percentage of POC funds		9.24%
TOTAL FUNDING			
	Overall POC Contracts		$2,605,468
	Overall Contractual Service		$17,701,301
	Percentage of POC Funds		14.72%

BOLD= New program in Y03

CARE MONITORING REPORT RATING CATEGORIES

(Version: 6/14/93 3:30 p.m..)

#	Rating Category *Time Period/Scope*	Points/ Weight Factor	Includes	Rating Ranges	Notes
1.	Accomplishment of Objectives *Program*	14 *2.8*	• Accomplishment of process objectives (excluding UOS/UDC) • Accomplishment of outcome objectives • Success in serving contracted target population	5/Bonus= Exceeded contract objectives 4 = 76 - 100% completed 3 = 51 - 75% completed 2 = 26 - 50% completed 1 = 1 - 25% completed 0 = 0% completed	Team will assign a score to each objective and then will average scores for total score for this category
2.	Timely Completion of Work *Current contract year*	5 *1.0*	Timeline only (exclude UOS/UDC)	5/Bonus = Activities completed early 4 = Activities completed on time 3 = Activities completed 15-30 days late 2 = Activities completed 31-45 days late 1 = Activites completed 45 days to date of monitoring 0 = Activities not completed	
3.	Quality of Work Performed in: *Program*	10 *2.0*	• Compliance with program policies, procedures, & standards • Outcome of evaluations • Implementation of QA and compliance with QA procedures • Results of QA	5/Bonus = Exceeds standards for compliance, evaluations show exceptional success 4 = Program fully implemented all policies, procedures, & QA, & results of evaluations show consistent success 3 = Program fully implemented all policies, procedures, & QA, & results of evaluations & QA indicate room for improvement 2 = Program complies inconsistently, & results of evaluations are mixed and indicate room for improvement 1 = Program compliance with standards is poor, and evaluations indicate substantial problems 0 = No compliance, no implementation; extremely poor outcomes of evaluations and QA	
4.	Quantity of Work Performed *Program*	15 *3.0*	UOS/UDC only Sample testing of selected month of UOS	5/Bonus = Provided more than 100% of contract 4 = Provided 90 - 100% 3 = Provided 70 - 89% of contract 2 = Provided 50 - 69% of contract 1 = Provided 1 - 49% of contract 0 = Did not provided or report any deliverables	UDC and UOS are weighted between prior and current year (see attached formula) then factored at 50% each into this score

#	Rating Category *Time Period/Scope*	Points/ Weight Factors	Includes	Rating Ranges		Notes
5.	Timely Submission of Materials to DPH: • quarterly reports • response to protocols *Program*	5 *0.6*	Based on DPH tracking for quarterly reports, etc., for current contracts	5/Bonus = 4 = 3 = 2 = 1 = 0 =	Submitted early Submitted on time Submitted within 15 days Submitted within 15 to 30 days Submitted later than 31 days, to date of monitoring Did not submit	Each type of document is scored, then scores are added and averaged for total score for this category
6.	Program Evaluation Procedures *Program*	7 *1.4*	For both Process & Outcome: • Adequate evaluation plan for 93-94 • Completion of evaluation plan for 92-93 (Excludes Quality Assurance)	5/Bonus = 4 = 3 = 2 = 1 = 0 =	Exemplary plan, implemented Appropriate plan and implemented Plan needs minor improvement and/or not fully implemented Plan needs major improvement and/or barely implemented Plan not implemented No plan	AO will provide checklist for different types of client files
7.	Client Record Documentation *Program*	8 *1.6*	Review of client records for completeness and accuracy	5/Bonus = 4 = 3 = 2 = 1 = 0 =	Records document all items on checklist, and an excellent understanding of client and client plan is found; confidentiality is assured. Records document all items on checklist, but documentation is slightly less clear and consistent Some documents are missing or incomplete (as compared to agency sample) Files show significant inconsistencies, or significant documents are missing or incomplete Files show gross inconsistencies Innapropriate release of records, majority of documents are missing, no treatment plan: actual or potential breach of ethical or legal standards	

#	Rating Category *Time Period/Scope*	Points/ Weight Factors	Includes	Rating Ranges		Notes
8.	Program Policies & Procedures *Current contract year*	6 1.2	• Existence of program policies & procedures/standards and client notification materials, such as: Patient rights Client grievance procedure TB screening Universal precautions Forms & order of case files • Staff training in program policies and procedures • Existence of QA procedures	5/Bonus = 4 = 3 = 2 = 1 = 0 =	All policies & procedures are documented, thorough and well designed, exceptional training, policies reviewed and updated annually, are compiled and accessible All policies & procedures are documented, are generally complete, staff training is provided, policies are compiled and accessible Policies & procedures are generally complete but not comprehensive, staff are adequately trained Documentation of policies and procedures available, but some are not complete or comprehensive, no evidence of review & updating, staff training is inadequate Majority of documents not available, complete, or current, no training plan No documented policies & procedures, no staff training	
9.	Administrative Practices *Agency-wide*	10 2.0	Personnel policies and practices Personnel manual Personnel files Board governance and composition By-laws and articles of incorporation Minutes	5/Bonus = 4 = 3 = 2 = 1 = 0 =	All documents comprehensive, reviewed and updated annually, reflect appropriate practices, Board governance is active & thorough All documents complete, reflect appropriate practices, compliance with policies Board or staff composition not in compliance with DPH policy; some documentation missing or needs improvement; practices generally appropropriate Personnel policies or other documentes or practices need significant expansion or updating Board minutes and personnel files show major inconsistencies between policy and practice No personnel policy manual, incomplete or no personnel files, no Board minutes	

#	Rating Category *Time Period/Scope*	Points/ Weight Factors	Includes	Rating Ranges		Notes
10.	Program Environment /Accessibility *Current contract year*	5 *1.0*	Includes: • ADA • site location • cultural competency • staffing adequacy • outreach & case-finding activities • program hours • physical condition of building	5/Bonus = 4 = 3 = 2 = 1 = 0 =	Exceptional efforts to comprehensively address cultural competency and accessibility for target population Demonstrates a good understanding of needs of the target population Demonstrates a basic understanding of target population, with some room for improvement Lacking in some elements and sensitivity needed for target population to feel at ease Lacking sensitivity to physical and cultura needs of target population Program or agency is discriminatory	
11.	Fiscal Practices *Agency-wide*	10 *2.0*	Fiscal policies and practices Audit completion Completeness and accuracy of selected financial records	5/Bonus = 4 = 3 = 2 = 1 = 0 =	All documents comprehensive, reviewed and updated annually, reflect appropriate practices, Board governance is active & thorough All documents complete, reflect appropriate practices, compliance with policies, Board consistently reviews and acts on financial information Some improvement needed in documentation or practice, Audit delayed up to 3 months*, or included minor recommendations Audit delayed 3 to 5 months*, improvement needed in documentation or practice; majority of financial records sampled are inaccurate or incompleted No or inadequate documentation of fiscal practices; Audit delayed more than 5 months*, A-133 audit not performed, major improvements in practices needed; all samples inaccurate or incomplete Audit delayed more than 9 months; inadequate accounting controls or Board oversight; unable to sample test due to lack of records or accessibility	

* *Independent audit reports are generally due to the AIDS Office within 90 days of the end of the contractor's fiscal year.*

#	Rating Category *Time Period/Scope*	Points/ Weight Factors	Includes	Rating Ranges		Notes
12.	Collaborative Efforts *Program*	5 *1.0*	• MOUs & Letters of Cooperation Existence of documentation Adequacy of documentation Practice and implementation	5/Bonus = 4 = 3 = 2 = 1 = 0 =	Exceptional efforts to cooperate and demonstrate cooperative linkages with other providers All basic relationships are adequately documented and implemented Documentation of relationships needs some improvement, but vital relationships are in existence Lacking some vital or crucial relationships Lacking all vital or crucial relationships No cooperative linkages are demonstrated or in evidence	

OVERALL CARE PROGRAM RATING

Points	Rating	Possible Consequences
85-100	COMMENDABLE	• Letter of commendation. • Possibly no site visit or limited site visit next year • Possible recommendation for multi-year contract.
60 - 84	ACCEPTABLE	• Possible recommendation for multi--year contract. • Recommendations for improvement.
40 - 59	IMPROVEMENT NEEDED	• Recommendations for improvement. • Re-bidding automatically considered. ** • Required reevaluation with the following possible progressive consequences as determined by the monitoring team: + technical assistance & training requirements + probationary status*
0-39	UNNACCEPTABLE	• Recommendations for improvement. • Re-bidding automatically considered. ** • Required reevaluation with the following possible progressive consequences as determined by the monitoring team: + technical assistance & training requirements + probationary status* + defunding*

*Probationary status can include receivership. Probationary status can be recommended at any time for failure to comply with basic contractual requirements, specified policies and procedures or performance requirements. Defunding can be recommended at any time for continued failure to comply with performance requirements, failure to address recommended interventions and timelines during a probationary period, gross infraction of the law, significant inability of the Board of Directors to manage the organization, significant inability of the organizations staff to deliver services and manage day to day operations, or because a service is no longer needed. Please see the separate Planning Council policy on the probationary process.

** Re-biddingor non-renewal of existing may be considered at any time due to re-prioritization of service needs. Any program with an overall monitoring score of 59 or below will be considered for possible re-bidding.

o\rfps\procedur\caresum.doc

PROPOSED CARE PROGRAM MONITORING RATINGS
Presented to the Planning Council on **6/21/93**

Attached is the first complete draft of the proposed rating mechanism for monitoring CARE contracted programs. The overall rating scheme works on a base of 100 points, with ratings of 0 to 5 which are then multiplied by a straight weight factor to arrive at the score for that category.

If Program Received:	Total Score Would Be:
All 0's	0
All 1's	20
All 2's	40
All 3's	60
All 4's	80
All 5's	100

We have maintained four overall ratings, which are described on the last page of this document: Commendable, Acceptable, Needs Improvement, and Unnacceptable. Please note on the final page, that the spread of points assigned to each of these overall categories can be changed without changing the weights.

HIV HEALTH SERVICES PLANNING COUNCIL

July 12, 1993

The Agenda of this meeting is missing.

San Francisco Public Library
Government Information Center

HIV HEALTH SERVICES PLANNING COUNCIL
July 12, 1993
25 Van Ness Avenue, Fifth Floor
4:30 - 7:00 p.m.

MEMBERS
Present: Pat Christen, Marcy A.Fraser, Yvonne Frazier, Estela Garcia, Lester D. Hanson, Sandra R. Hernandez, Susan Karp, Gerald Lenoir, Gifford S. Leoung, Steve Lew, Kent Macdonald, Scott Miller, J. B. Molaghan,Bob Nelson, Elliot S. Ramos, Steve Roger, Mike Shriver, Rita Times, Jerry Windley, Mary Jane Wood **[20]**
Absent: Barbara Garcia, Jaime Geaga, Karen F. Hembry, Laura Thomas, Reggie Williams.

Staff Present: Sophia Chang, James Loyce, Jr., George Lemp, Bill Haskell, Valerie Dorr Judith Weld, Charles Brand

I. Roll Call

Roll call was taken as above.

II. Review of Minutes and Agenda.

June 14 minutes: Approved. Marcy Fraser and Mike Shriver abstained.
June 21 minutes: Section **V.B.** was modified to read: "*Non-response* will be deemed an effective resignation." Approved, with Mike Shriver abstaining.

III. General Announcements.

Mike Shriver announced that July 19 and 20 are "Advocacy Days," for lobbying the U.S. Senate in support of Title I appropriations.

IV. Review of San Francisco's HIV Seroprevalence

Dr. George Lemp distributed and reviewed the AIDS Office/Surveillance document *Estimates of the Number of Persons Infected with HIV in San Francisco by Race/Ethnicity* (copy attached). An earlier report based on the 1991 meeting estimated prevalence by risk population and gender, but not by race and ethnicity. This report is a follow-up, incorporating some new information to update the old. All surveys show increased prevalence of infection among people of color, and we expect the shift to continue. Further, this study demonstrates the great difference between various groups in the ratio of HIV infection to AIDS cases. The People of Color Advisory Committee has also discussed the findings.

Q- Why are there no figures for transfusion recipients or hemophiliacs? **A-** There is no reliable estimate of this population. They are included under the "Other" category. (The AIDS Office estimates the size of an infected population by: estimating the size of the population at risk; estimating the prevalence of infection (based on survey information); and multiplying the two figures together.)

Q- What ages are defined as "adolescent"? **A-** It depends on the survey. Sometimes up to 21 years. This report combines adolescents with adults, which includes all those aged 13 and over.

Q- Can't we be more specific than "Gay Injection Drug Users"? Aren't the figures based on methadone programs? Most gay intravenous drug users are amphetamine users, and I think these figures are too low. **A-** The AIDS Office estimates that the population size has not changed significantly. The "Young Men's Survey" data disclosed for the first time an upsurge of injection drug use among youth that other studies missed. Dr. Sandra Hernandez noted that current seroprevalence studies are being conducted in fewer methadone clinics. Dr. George Lemp said that only two clinics were being studied, so that the "Injection Drug Use" category was not specific to methadone clinic data, but also used street-based surveys and Young Men's Survey data. The estimate was worked out a few years ago and not rethought for this study, which has a race and ethnicity focus. Actually this is the only one of all risk groups whose numbers are declining.

Q- Why isn't there a socio-economic focus? This would be extremely valuable for the Planning Council, particularly in advocating reimbursements. **A-** Few surveys provide this type of information, and age and income are among the most difficult information to obtain. Dr. Chang reported that the client-based needs assessment would provide data on income and insurance status. The AIDS Office has been in the field for three or four weeks, and so far has received about 300 or 400 responses, of which maybe 150 are valid. The objective is 2,000 valid responses.

Q- Were there any surprises in the seroprevalence findings? **A-** There were in the Young Men's Survey, but not in this summary report. The level of risk and prevalence of infection among African-Americans remains disconcerting. Dr. Hernandez found that the most striking item in the Young Men's Survey was the very high level of knowledge, yet very high level of high-risk behavior. The discrepancy in those two categories is really quite profound. Dr. Lemp noted that 70% of the seropositive in the Young Men's Study were not aware that they were infected, and never came back for results. Moreover, the rate of unprotected anal sex was the same, regardless of awareness of serostatus. Some Federal resources need to be shifted from counseling and testing to health education and risk reduction. The biggest predictors were peer group norms and similar things.
Q- What is your reference for this information? **A-** From Young Men's Survey data that has not yet been released. The AIDS Office is preparing this information for publication.

Q- How did the AIDS Office determine the size of San Francisco's gay population? **A-** This number is extrapolated from a composite of surveys, all with different biases.

Q- How are composites for different populations derived? **A-** This report includes a description of the methodology used. The estimate of the gay/bisexual population (third data page) is based on a composite of various studies. The San Francisco Men's Health Study was not utilized, since it is based on older data and confined to 19 census tracts in the Castro area. The 1990 Communications

Technology Study --- a telephone survey; and the recently completed Young Men's Survey (street- and club-based) were used; as were STD clinic data and race/ethnicity distributions from the 1990 census. There were many random as well as targeted studies, and it is generally difficult to obtain adequate numbers of gay and non-white respondents. The Young Men's Survey helped overcome this inadequacy, and is the only one that approximates census data. The data was not brand new, although information from some new studies was included. Much of the basic data was from the September 1991 meeting with its report released in early 1992. The population of persons with HIV is a dynamic situation. Current figures are a balance of new infections at one end and death at the other.

V. Report from the Working Group on the Transfer of A.I.D.S. programs

Gerald Lenoir presented and discussed the subcommittee's recommendations. These are to:
(1) Allow A.I.D.S. to modify their 1993/1994 renewal contracts to support a .80 FTE Fiscal Manager position;
(2) Set aside $79,991 for Representative Repayee and Security Deposit Payment Services for clients residing in the Tenderloin area, and rebid these services; and
(3) Request that the AIDS Office notify potential providers to assess their level of interest and capability for providing these services.

Q- How do the recommendations differ from what the Council originally discussed? **A-** James Loyce noted that the outcome was identical; but it was derived from a longer review. He felt that it would not be difficult to implement the recommendations.

Gerald Lenoir made this motion:

> ***The Planning Council accepts the report and recommendations outlined in the subcommittee's July 12 memorandum to the Planning Council.***

Dr. Sandra Hernandez noted that no one with a conflict of interest should vote. The motion was accepted, with none opposed. Pat Christen and Bob Nelson abstained.

VI. Plan for "Strategic Monitoring"

Bill Haskell gave the Council two AIDS Office draft documents: (1) *Proposal for Strategic Monitoring: Presented to the Planning Council on 7/12/93* with *1993 Care Monitoring Schedule* attached (3 pp.); (2) *AIDS OFFICE Care Monitoring Report Summary* (3 pp.). [See attached.]

The fluid staffing situation, involving replacement of some key staff by persons from outside the AIDS Office, prevent full-scale monitoring visits of all 131 CARE-funded programs. Even a full complement of capable staff this year could not monitor every site within the working calendar time frame. Focus will be on 30 programs that were not monitored last year, either because they were new, or were one-time funded programs that were renewed. The other sites would complete the equivalent of a program report, which would not be rated.

Q- Which programs are the "new" ones? A- Those new programs funded in 1992-1993.

Q- What about those beginning this fiscal year? A-They will receive a short checklist to complete. They will have been in operation only one month and have little to report.

Q- Is it a goal to monitor every site in the future? A- Dr. Chang did not know if annual monitorings of all programs were feasible. Steve Roger suggested doing a percentage each year, with all programs being monitored in a three- or four-year cycle.

Q- Isn't there a difference between writing and looking? A- Dr. Hernandez agreed that visiting a site might help detect problems earlier; as well as give staff a better working knowledge of the site's operations. Even on-site monitoring is not fail-proof unless it is intensive.

Estela Garcia stressed that monitoring can also reinforce what is positive and urged the Council to consider a rotation concept, with monitoring of all sites within a several year cycle. Bob Nelson observed how hard it has been to get enough Council members to do site visits. He thought 30 was a formidable number. He suggested a new subcommittee to study the monitoring process.

Jerry Windley urged that some old programs be included to fulfill the Council's fiscal oversight responsibility. Gerald Lenoir suggested that one approach would be to segregate the fiscal from the programmatic. Pat Christen argued that it was imperative to monitor any agency receiving a substantial amount of funds. She made this motion:

> ***The Planning Council accepts the "Strategic Monitoring Plan" to monitor approximately 20 contracts.***

J.B. Molaghan made a friendly amendment to Pat Christen's motion, to emphasize ***new contracts***. This motion was accepted, with no opposing votes or abstentions:

> ***The Planning Council accepts the "Strategic Monitoring Plan" to monitor approximately 20 contracts, with priority to new programs.***

Pat Christen suggested that two Council members review a site's annual report and conduct the visit. Kent Macdonald agreed that this would bolster the Council's oversight role. Dr. Hernandez asked what would be the procedure for determining which members visited which agencies; and who would schedule this? Did the Council wish to assume the task of coordination?

Bob Nelson made this motion, which was passed without opposition or abstention:

> ***The Council forms a task force to look at how the Council shall participate in site visits. The task force will report to the Council at its July 26 meeting.***

The task force will include Bob Nelson, Kent Macdonald, Steve Roger and Rita Times. Bill Haskell will be the staff member. Dr. Hernandez welcomed this initiative. She is interested in any monitoring concepts the task force can provide, especially trigger mechanisms for site visits based on contractor reporting.

Dr. Chang felt it was imperative to focus on new sites, given the limitation in the number of feasible site visits. Dr. Hernandez added that agencies with multiple contracts have had at least one monitoring visit. In addition, program managers will follow up on recommendations from last year's monitoring reports.

VII. Update on Year 3 Funding (Revised Summary of PEOPLE OF COLOR Agency Funding).

Dr. Sophia Chang led discussion of the AIDS Office document *YO3 CARE Funding for People of Color Target Population* (2 pp.) [see attached]. No substance abuse program data was included, an oversight on the part of the AIDS Office. Dr. Sandra Hernandez noted that much primary care funding was within the Health Department. Technically it was not a people of color agency, but its client composition was clearly within the spirit of people of color as a target population. Gerald Lenoir suggested that the Council revisit its people of color funding targets, with an emphasis on service types. Dr. Hernandez said that the study would be referred to the People of Color Advisory Committee for further recommendations.

VIII. Update on Planning Processes--Long-Range and Housing

Dr. Sophia Chang updated the Council on its contract with the Support Center to facilitate the long-range planning process for HIV services in San Francisco. The focus, or end-point, of this process will be to develop a "blueprint" for HIV services, making the system more "user friendly." A meeting is scheduled with the Support Center on July 16 at the AIDS Office. A series of focus groups will be held with consumers to build on the AIDS Office client-based assessment project.

Dr. Chang called for other Council members to join Estela Garcia, Steve Lew and Gerald Lenoir on the Long-Range Planning Subcommittee. Dr. Sandra Hernandez requested that the AIDS Office staff develop a listing and discussion of all AIDS Office assessment activities that might impact on policy and planning.

Bill Haskell passed out two AIDS Office documents: *Planning Timeline for AIDS Housing Services in San Francisco* (July 12, 1993; 1 page); *San Francisco AIDS Housing Model* (Draft, July 7, 1993; 4 pages). [See attached.] He announced that the San Francisco Housing Redevelopment Agency is conducting a housing needs assessment. The effort began independently but is clearly related to long-range planning. The study is not as comprehensive as the client-based needs assessment, but is specific to housing needs. It also focuses on access to housing services and benefits. The Redevelopment Agency expects to receive 150-200 of the 700-900 questionnaires being distributed to clients. A second survey will go to providers.

Q- Wasn't the transition of Shanti housing programs to occur in October? **A-** (Bill Haskell:) The AIDS Office is looking at the best time for the transition and is trying to abbreviate the usually protracted award process.using various approaches (e.g., alternative solicitation process, sole source, letter of intent). The current timeline objective is for a January 1994 transition of the Shanti housing programs to new service providers.

Dr. Hernandez noted that we need a second member to sit with Marcy Fraser on the Redevelopment Agency's Loan Committee.

IX. Review of Future Meetings.

All meetings are scheduled for 4:30 - 7:30 p.m. except for the Columbus Day meeting (October 11), which is scheduled for 4:00 - 9:00 p.m..

July	26
August	16, 30.
September	13, 20, 27.
October	4, 11*, 18, 25
November	8, 22
December	6, 20.

Dr. Sophia Chang advised that her staff is developing a list of accessible alternative meeting sites. Public schools will be unavailable until September.

The Council adjourned at 7:00 PM.

o/wp/council.doc:2

DOCUMENTS DEPT.
JUL 22 1993
SAN FRANCISCO
PUBLIC LIBRARY

ESTIMATES OF THE NUMBER OF PERSONS INFECTED WITH HIV IN SAN FRANCISCO BY RACE/ETHNICITY

SURVEILLANCE BRANCH, AIDS OFFICE

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

JUNE 28, 1993

I. EXECUTIVE SUMMARY

This report provides estimates of the prevalence of HIV infection by race and ethnicity in the City and County of San Francisco in 1993. These data are based upon the large body of research that has been conducted in San Francisco during the past decade, and include estimates of the number of persons at risk, the prevalence of HIV, and the number of persons infected with HIV.

It is estimated that approximately 28,000 men, women and children are currently living with HIV infection in 1993, representing almost 4% of the City's population. San Francisco has the highest number of HIV-infected persons per capita of any major city within the United States.

It is estimated that the majority of persons currently living with HIV infection in San Francisco are white (61%), most of whom are gay and bisexual men. Persons of color represent 39% of those currently infected with HIV. In 1992, only 25% of persons diagnosed with AIDS were persons of color. Together, these findings suggest a shift in recent years towards increasing numbers of infections among persons of color.

It is estimated that the vast majority of persons infected with HIV in San Francisco are either gay and bisexual men, injection drug users, or sexual partners of gay and bisexual men or injection drug users. Although the majority of gay and bisexual men currently living with HIV infection are white, most injection drug users or infants and children living with HIV are persons of color.

The following points highlight the key findings from this report:

1. An estimated 28,000 men, women, and children are living with HIV infection in San Francisco in 1993, representing nearly 4% of the City's population.

2. Of the 28,000 persons estimated to be living with HIV, approximately 25,000 are gay and bisexual men, 1,700 are injection drug users (other than gay and bisexual males), 880 are women and heterosexual men with other risks, and 83 are infants or children.

3. More than 10,700 persons of color are currently living with HIV infection in San Francisco, representing 39% of all those currently infected with HIV.

4. Among those living with HIV infection, 61% are white, 16% are African American, 14% are Latino, 8% Asian/Pacific Islander, and 1% are Native American.

II. METHODS

Estimates of the number of persons infected with HIV are derived from estimates of the prevalence of HIV infection and the size of the populations at risk. These estimates are based upon numerous studies conducted in San Francisco in recent years, including probability samples of San Francisco neighborhoods, cohort studies of gay and bisexual men, random digit-dial telephone surveys, clinic-based unlinked serosurveys, studies of young men who have sex with men, surveys of childbearing women, studies of heterosexual partners, street-based studies of injection and non-injection drug users, and screening of blood donors.

The estimated numbers of gay and bisexual men by race/ethnicity was based on a composite of distributions from the following sources: reported cases of persons diagnosed with AIDS in 1992, a random digit-dial survey of gay and bisexual men (Communications Technologies, 1990), a survey of young men who have sex with men conducted in 1992 and 1993 (Young Men's Survey, 1992/93), an unlinked HIV seroprevalence survey at a sexually transmitted disease clinic (City Clinic, 1991), and data from the 1990 U.S. census.

The estimated numbers of injection drug users by race/ethnicity was based on a composite of distributions from the following sources: population-based household surveys of African Americans (Polaris Research & Development, 1989), Latinos (Fairbank, Bregman and Maullin, 1989), Filipinos (The Asian American Health Forum/Filipino Task Force on AIDS, 1990), Chinese (Asian American Recovery Services, 1990), Japanese (Asian American Recovery Services, 1990), and Southeast Asians (Center for Southeast Asian Refugee Resettlement, 1991). Other sources of data included unduplicated counts of clients in treatment (Community Substance Abuse Services, SFDPH, 1990-91), reported cases of persons diagnosed with AIDS in 1992, unlinked HIV seroprevalence surveys at several drug treatment centers, street-based surveys of drug users (Urban Health Study, 1991-92) and data from the 1990 census.

Estimates of the total number of adults and adolescents and infants and children are based on the 1990 U.S. census. The population estimates for women and heterosexual men with other risk factors are calculated by subtracting the population size estimates for other categories (gay and bisexual men, IDUs, and infants and children) from the total San Francisco population estimates by race and ethnicity.

ESTIMATES OF THE NUMBER OF PERSONS INFECTED WITH HIV IN SAN FRANCISCO BY RACE/ETHNICITY

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH AIDS OFFICE

RISK GROUP	WHITE	AFRICAN AMERICAN	LATINO	ASIAN/ PACIFIC IS.	NATIVE AMERICAN	OTHER	TOTAL
ay and Bisexual Men							
Non-IDUs	14,587	3,028	3,355	2,027	161	NA	23,158
IDUs	1,223	210	234	142	11	NA	1,820
SUB-TOTAL	15,810	3,238	3,589	2,169	172	NA	24,978
jection Drug Users							
Heterosexual Men	418	637	103	21	8	2	1,188
Women	158	290	44	6	3	1	502
SUB-TOTAL	576	927	147	27	11	3	1,690
ther Adults/Adolescents							
Heterosexual Men	120	44	33	38	1	2	239
Women	376	139	72	46	4	2	639
SUB-TOTAL	496	183	105	84	6	4	878
fants and Children	29	29	16	8	1	0	83
OTAL	16,910	4,378	3,857	2,288	189	7	27,629
IV SEROPREVALENCE	5.0%	5.7%	3.8%	1.1%	7.2%	0.5%	3.8%
VING AIDS CASES s of March 31, 1993)	3,911	584	531	109	20	NA	5,155
ATIO IV INFECTION TO AIDS CASES)	4.32	7.50	7.26	20.99	9.47	NA	5.36

ESTIMATED POPULATION SIZE BY RACE/ETHNICITY

SAN FRANCISCO, 1993

RISK GROUP	WHITE	AFRICAN AMERICAN	LATINO	ASIAN/ PACIFIC IS.	NATIVE AMERICAN	OTHER	TOTA
Gay and Bisexual Men							
Non-IDUs	35,578	5,506	7,802	5,792	322	0	55,00
IDUs	1,941	300	426	316	18	0	3,00
SUB-TOTAL	37,519	5,806	8,228	6,107	340	0	58,00
Injection Drug Users							
Heterosexual Men	3,979	2,961	977	472	77	34	8,50
Women	2,106	1,568	517	250	41	18	4,50
SUB-TOTAL	6,085	4,529	1,494	722	118	52	13,00
Other Adults/Adolescents							
Heterosexual Men	120,043	22,094	33,178	76,447	606	704	253,07
Women	150,446	30,936	39,956	91,197	1,121	704	314,35
SUB-TOTAL	270,489	53,029	73,134	167,643	1,727	1,408	567,43
Infants and Children	23,025	12,979	17,861	31,213	451	NA	85,52
TOTAL	337,118	76,343	100,717	205,686	2,635	1,460	723,95

POPULATION ESTIMATES OF GAY/BISEXUAL MEN
SAN FRANCISCO, 1993

	WHITE	AFRICAN AMERICAN	LATINO	ASIAN/ PACIFIC IS.	NATIVE AMERICAN	OTHER	TOTAL
AIDS CASES '92	0.7978	0.0754	0.1027	0.0193	0.0048	NA	1.0000
	46,272	4,373	5,957	1,119	278	NA	58,000
SMHS '84 (NOT USED)	0.876	0.04	0.054	0.03	NA	NA	1.0000
	50,808	2,320	3,132	1,740	NA	NA	58,000
COMMUNICATION	0.83	0.04	0.08	0.045	0.005	NA	1.0000
TECHNOLOGIES, 1990	48,140	2,320	4,640	2,610	290	NA	58,000
YIS 1992/93	0.497	0.122	0.225	0.15	0.006	NA	1.0000
	28,826	7,076	13,050	8,700	348	NA	58,000
SD UNLINKED 1991	0.63	0.16	0.16	0.04	0.01	NA	1.0000
	36,540	9,280	9,280	2,320	580	NA	58,000
POPULATION DISTRIBUTION	0.4796	0.1031	0.1416	0.2722	0.0035	NA	1.0000
('90 CENSUS)	27,817	5,980	8,213	15,788	203	NA	58,000
COMPOSITE	0.6469	0.1001	0.1419	0.1053	0.0059	0.0000	1.0000
	37,519	5,806	8,228	6,107	340	0	58,000

POPULATION ESTIMATES OF INJECTION DRUG USERS
SAN FRANCISCO, 1993

	WHITE	AFRICAN AMERICAN	LATINO	ASIAN PACIFIC IS.	NATIVE AMERICAN	OTHER	TOTAL
AIDS CASES, 1981-92	0.4023	0.4417	0.141	0.0113	0.0037	0	1.0000
	5,230	5,742	1,833	147	48	0	13,000
POPULATION BASED	0.5196	0.2437	0.0747	0.1527	NA	0.0093	1.0000
SURVEYS, 1989-91	6,755	3,168	971	1,985	0	121	13,000
UNLINKED HIV SURVEYS,	0.6004	0.2381	0.122	0.0292	0.0037	0.0066	1.0000
1990	7,805	3,095	1,586	380	48	86	13,000
URBAN HEALTH STUDY,	0.35	0.47	0.122	0.029	0.029	0	1.0000
1991-92	4,550	6,110	1,586	377	377	0	13,000
COMPOSITE	0.4681	0.3484	0.1149	0.0556	0.0091	0.0040	1.0000
	6,085	4,529	1,494	722	118	52	13,000

HIV PREVALENCE AMONG WHITES
SAN FRANCISCO, 1993

RISK GROUP	WHITE	HIV PREVALENCE	TOTAL INFECTED
ıy and Bisexual Men			
Non-IDUs	35,578	41.00%	14,587
IDUs	1,941	63.00%	1,223
SUB-TOTAL	37,519		15,810
ection Drug Users			
Heterosexual Men	3,979	10.50%	418
Women	2,106	7.50%	158
SUB-TOTAL	6,085		576
ıer Adults/Adolescents			
Heterosexual Men	120,043	0.10%	120
Women	150,446	0.25%	376
SUB-TOTAL	270,489		496
ıants and Children	23,025	0.13%	29
TAL	337,118		16,910

HIV PREVALENCE AMONG AFRICAN AMERICANS
SAN FRANCISCO, 1993

RISK GROUP	AFRICAN AMERICANS	HIV PREVALENCE	TOTAL INFECTED
Gay and Bisexual Men			
Non-IDUs	5,506	55.00%	3,028
IDUs	300	70.00%	210
SUB-TOTAL	5,806		3,238
Injection Drug Users			
Heterosexual Men	2,961	21.50%	637
Women	1,568	18.50%	290
SUB-TOTAL	4,529		927
Other Adults/Adolescents			
Heterosexual Men	22,094	0.20%	44
Women	30,936	0.45%	139
SUB-TOTAL	53,029		183
Infants and Children	12,979	0.22%	29
TOTAL	76,343		4,378

HIV PREVALENCE AMONG LATINOS
SAN FRANCISCO, 1993

RISK GROUP	LATINOS	HIV PREVALENCE	TOTAL INFECTED
ay and Bisexual Men			
Non-IDUs	7,802	43.00%	3,355
IDUs	426	55.00%	234
SUB-TOTAL	8,228		3,589
ection Drug Users			
Heterosexual Men	977	10.50%	103
Women	517	8.50%	44
SUB-TOTAL	1,494		147
her Adults/Adolescents			
Heterosexual Men	33,178	0.10%	33
Women	39,956	0.18%	72
SUB-TOTAL	73,134		105
ants and Children	17,861	0.09%	16
OTAL	100,717		3,857

HIV PREVALENCE AMONG ASIANS/PACIFIC IS.
SAN FRANCISCO, 1993

RISK GROUP	ASIAN/ PACIFIC IS.	HIV PREVALENCE	TOTAL INFECTED
Gay and Bisexual Men			
Non-IDUs	5,792	35.00%	2,027
IDUs	316	45.00%	142
SUB-TOTAL	6,107		2,169
Injection Drug Users			
Heterosexual Men	472	4.50%	21
Women	250	2.50%	6
SUB-TOTAL	722		27
Other Adults/Adolescents			
Heterosexual Men	76,447	0.05%	38
Women	91,197	0.05%	46
SUB-TOTAL	167,643		84
Infants and Children	31,213	0.03%	8
TOTAL	205,686		2,288

HIV PREVALENCE AMONG NATIVE AMERICANS
SAN FRANCISCO, 1993

RISK GROUP	NATIVE AMERICANS	HIV PREVALENCE	TOTAL INFECTED
Gay and Bisexual Men			
Non-IDUs	322	50.00%	161
IDUs	18	60.00%	11
SUB-TOTAL	340		172
Injection Drug Users			
Heterosexual Men	77	10.00%	8
Women	41	8.00%	3
SUB-TOTAL	118		11
Other Adults/Adolescents			
Heterosexual Men	606	0.20%	1
Women	1,121	0.40%	4
SUB-TOTAL	1,727		6
Infants and Children	451	0.20%	1
TOTAL	2,635		189

6-28-93

ESTIMATED HIV SEROPREVALENCE
BASED ON DISTRIBUTION BY RACE/ETHNICITY

RISK GROUP	POPULATION SIZE	NUMBER INFECTED	HIV PREVALENCE
Gay and Bisexual Men			
Non-IDUs	55,000	23,158	42.11%
IDUs	3,000	1,820	60.65%
SUB-TOTAL	58,000	24,978	43.07%
Injection Drug Users			
Heterosexual Men	8,500	1,188	13.98%
Women	4,500	502	11.17%
SUB-TOTAL	13,000	1,690	13.00%
Other Adults/Adolescents			
Heterosexual Men	253,071	239	0.09%
Women	314,359	639	0.20%
SUB-TOTAL	567,431	878	0.15%
Infants and Children	85,529	83	0.10%
TOTAL	723,960	27,629	3.82%

DEPARTMENT OF PUBLIC HEALTH
AIDS OFFICE
CARE MONITORING REPORT SUMMARY

This is the official monitoring report for the provision of HIV services funded through the AIDS Office, San Francisco Department of Public Health. Comments in answer to points raised herein may be made in writing and addressed to the AIDS Office per instructions in the cover letter transmitting this report. Copies of the response will then be filed along with each report.

FISCAL AGENT: _____ DATE OF VISIT: _____
SERVICE PROVIDER: _____ DATE OF REPORT: _____
PROGRAM REVIEWED: _____ FUNDING SOURCE: CARE
FACILITY SITE: _____ CONTRACT AMOUNT: _____
AO PROGRAM MANAGER: _____ CONTRACT NUMBER: _____
FISCAL AGENT/PROVIDER REPRESENTATIVES: _____ CONTRACT TERM: _____

REVIEW TEAM MEMBERS: Judith Weld

Type and Scope of Review (Circle All That Apply)

Site Visit | Client Records | Staff Interviews | Personnel Records | Administrative
Contract Performance Review | Client Feedback | Director Interview | Policies and Procedures | Fiscal
Other: _____

Program Performance Rating (Rate from 4 to 1)

85-100 = Commendable | 60-84 = Acceptable | 40-59 = Improvement Needed | 1-39 = Unacceptable

ENTER APPROPRIATE RATING FOR EACH CATEGORY BELOW

1. _____Accomplishments of Objectives [0-14]
2. _____Timely Completion of Work [0-5]
3. _____Quality of Work Performed [0-10]
4. _____Quantity of Work Performed [0-15]
5. _____Timely Submission of Materials to AO [0-5]
   a. ____Quarterly Reports
   b. ____Response to Protocols
   c. ____Contract Documents
6. _____Program Evaluation Procedures [0-7]
7. _____Client Record Documentation [0-8]
8. _____Program Policies & Procedures [0-6]
9. _____Administrative Practices [0-10]
10. _____Program Environment/Accessibility [0-5]
11. _____Fiscal Practices [0-10]
12. _____Collaborative Efforts [0-5]
13. _____Other:_____

OVERALL RATING_____

	YES	NO
Is the ethnic designation of staff and Board in compliance with Health Commission requirements?		
If not, has a satisfactory plan to achieve compliance been submitted?		
Has the fiscal agent's audit report been received by the AIDS Office?		
If not, what is the anticipated date of submission?		

COMMENDATIONS

IDENTIFIED PROBLEMS, RECOMMENDED INTERVENTIONS AND TIMELINE:

DPH AIDS OFFICE
CARE MONITORING REPORT SUMMARY
SIGNATURE PAGE

FISCAL AGENT/PROVIDER/PROGRAM:_____
CONTRACT NUMBER & TERM:_____
FUNDING SOURCE & AMOUNT:____CARE_____
AIDS OFFICE PROGRAM MANAGER:_____
DATE OF REPORT:_____

Please see preceding pages for commendations, identified problems, recommended interventions and timelines.

This Report Has Been Reviewed and Accepted By AIDS Office-Departmental Review:

Author(s) of this Report	Title(s)	Date
James Loyce Jr., Associate Director for Administration		Date

CONTRACTOR/ PROVIDER RESPONSE

___I have reviewed the Monitoring Report and acknowledge findings. No further action is necessary.

___I have reviewed the Monitoring Report and acknowledge findings. Response to Recommendations is attached.

___I have reviewed the Monitoring Report and disagree with findings. Response to Recommendations is attached.

Signature & Title of Authorized Contract Signatory (Fiscal Agent) Date

Signature & Title of Authorized Contract Signatory (Service Provider) Date

FISCAL AGENT/PROVIDER RESPONSE DUE: _____

carex.dot
Form updated: 07/12/93

DRAFT

SAN FRANCISCO
AIDS HOUSING MODEL

July 7, 1993

OVERARCHING PRINCIPLES:

* Decentralization of intake for access & cultural competence.

* Centralization of waitlists for equity & efficiency.

* Concentration of expertise for effectiveness & quality of service.

I. COORDINATED ACCESS TO EXISTING HOUSING, AND NEW HOUSING AS IT BECOMES AVAILABLE

.Centralized information on available AIDS-specific and other housing maintained by one information and referral (I&R) agency.

.Centralized waiting list for housing units maintained by I&R agency. Referrals made when space available.

.Centralized waiting lists for housing subsidies and vouchers also maintained by I&R agency. Referrals made when subsidies & vouchers available.

.Decentralized housing intake coordinated by designated case managers.

.Decentralized intake for housing and housing support services provided by designated case managers. Housing to include emergency, transitional, and permanent options. Support services to include emergency housing vouchers and subsidies, money management, and benefits counseling.

.Final placement decisions made by housing providers to assure appropriate match between housing programs and clients.

II. EXPANDED HOUSING CAPACITY BY NEW AND EXISTING PROVIDERS

1. Concentration of housing expertise in a few AIDS service providers to develop and operate multiple housing programs. Requirements include:

.Provision of housing services as one of agency's major missions.

.Capability of operating large scale housing programs & services.

.Ability to achieve economies of scale (i.e., single management staff, bulk purchasing).

.Sophisticated fiscal and administrative systems to develop and operate a variety of housing programs.

.Substantial financial reserves to respond to cash flow issues.

.Capacity to develop diverse revenue streams through federal grant programs, commercial and public lenders, and non-profit development organizations.

.Strong fund raising capability.

.Dedicated staff to work with Housing Development Corporations.

2. Development and operation of specialty housing by numerous specialty housing providers. Requirements include:

.Provision of HIV services as agency's major mission.

.Capability of operating small scale housing programs & services.

.Sophisticated fiscal and administrative systems to develop and operate housing.

.Substantial financial reserves to respond to cash flow issues.

.Fund raising capability.

.Ability to be responsive in addressing gaps in San Francisco's housing continuum by developing appropriate housing.

3. Active Involvement of existing Housing Development Corporations.

.Housing Development Corporations (HDCs) as primary agents for housing development (negotiating site purchases, applying for financing, overseeing rehabilitation or new construction).

.Joint ventures between HDCs and AIDS service providers or specialty housing providers.

.Technical assistance contracts between HDCs and AIDS service providers or specialty housing providers.

.Set-asides of a percentage of HIV-specific housing units in large scale housing developments to benefit specific targeted groups.

4. Capacity Building for housing ownership and management.

.Collaborations between AIDS service providers and HDCs which develop, own and operate large scale housing developments. Ongoing supportive services would be committed by AIDS service providers in exchange for set-asides of HIV-specific units in large, mixed residency housing developments.

.Contracts between AIDS service providers or specialty housing providers (which plan to develop and own housing) & residential management companies (which operate and maintain housing).

.Technical assistance from HDCs and residential management companies about development and maintenance for those AIDS service providers and specialty housing providers that will be developing, owning and operating housing.

.Technical assistance from the AIDS Office about requirements of licensure, and about whether or not to seek licensure for specific housing programs.

.Financial assistance from HOPWA or CARE funds for renovations and staffing necessary to comply with licensure requirements.

III. CENTRALIZATION OF PLANNING FOR HOUSING DEVELOPMENT

1. A Housing Needs Assessment as a basis for planning.

2. A Comprehensive Housing Plan, to be endorsed by the HIV Health Services Planning Council, Health Commission, the Redevelopment Commission, the Mayor and Board of Supervisors.

3. An HIV Housing Providers Association to assist with planning to include: (a) regular assessment of housing services; (b) problem solving; (c) joint planning; and (d) identification of appropriate agencies to develop necessary housing.

4. HIV Housing Providers Association also to: (a) facilitate the cooperative development of housing by AIDS service providers and specialty housing providers with HDCs; (b) assist AIDS service providers and specialty housing providers to define housing programs and residential services; (c) assist HDCs to understand the housing needs of persons with AIDS and the roll they can play housing development; and (d) provide centralized information for AIDS service providers and specialty housing providers, and HDCs concerning AIDS housing development in San Francisco.

5. Proactive solicitation of agencies to fill gaps in housing continuum by developing needed housing.

IV. RECOGNITION OF NEED FOR ONGOING FUNDING FOR OPERATING EXPENSES & SUPPORTIVE SERVICES IN HOUSING DEVELOPMENTS

1. Ongoing funding for operating expenses and supportive services by HIV Planning Council, so that funds can be committed without rebid based on satisfactory performance.

2. Ongoing funding for culturally competent supportive services in both large scale housing developments and small scale specialty housing programs.

3. Service contracts to include unallocated hours for high demand periods in various housing developments and specialty housing programs.

DRAFT

Proposal for Strategic Monitoring
Presented to the Planning Council on 7/12/93

I. Immediate Strategy for Comprehensive CARE Monitorings in July and August 1992-93

A. Comprehensively monitor only those CARE-funded programs which were new in 1992-93, or which for other reasons did not receive full monitorings (e.g., those one-time funded programs which ended up being renewed.) A **comprehensive monitoring** includes: a) the provider responds to the full protocol, b) the Planning Council conducts a full site visit; and c) the Planning Council issues a report with scores. Some of these **comprehensive monitorings** will include the complete administrative and fiscal review; other providers will receive a modified fiscal and administrative review, based on the date and scope of the last review and the number and significance of outstanding issues.

Providers will have at least 10 days to respond to the report and their response will become an official part of the report. Providers may request a change in a score if it is based on a factual inaccuracy in the report. Any recommendations for defunding will of course be made via the approved Planning Council process.

The following will be included in this comprehensive monitoring cycle:

38 exhibits
30 programs
30 site visits
26 agencies

B. For remainder of the CARE funded programs, providers will be requested to submit:

A response to a shortened protocol
UOS/UDC Summary of Delivery

These documents would constitute an **"Annual Program Report"** which would replace the comprehensive monitoring. Please note that these reports would not include ratings or scores. The scope of administrative and fiscal reviews to be implemented for these programs will be determined based on the date and scope of the last review and the number and significance of outstanding issues.

AIDS Office staff would reserve the right to **comprehensively monitor** any program on an as-needed basis at any time, in order to investigate problems or issues that may arise. Providers selected for as-needed full monitorings would be given advance notice.

C. Per the new monitoring rating system, any program which receives a monitoring score of 59 points or lower will be considered for re-bidding by the Sub-Committee on Evaluation. There will be no "routine re-bidding". The Planning Council may also decide at any time to rebid or discontinue any program due to re-priorization or low utilization.

II. New Strategic Monitoring Strategy

A. The AIDS Office is proposing that the strategy described above be implemented as a standard strategic approach to monitoring CARE programs. Some implications of this strategy are as follows:

- The Planning Council and AIDS Office would no longer conduct annual comprehensive monitorings of every program.
- Only "new" programs would be extensively monitored during August of each year.
- The AIDS Office would need to present this approach to the Health Commission for their approval, so that it would not have to submit "monitoring reports" with scores when seeking to renew contracts.
- The AIDS Office would not have a baseline monitoring of every CARE program using the new rating system.
- Program Managers and Planning Council members would be able to conduct more thorough and effective monitorings of new programs, due to a more reasonable workload within the given timeframe.

B. The scope of administrative and fiscal reviews to be implemented for those programs which do not receive comprehensive programmatic monitorings will be determined based on the date and scope of the last review and the number and significance of outstanding issues.

t:(o\rfps\monitor)\care93pc

1993 CARE MONITORING SCHEDULE

7/02/93	.Mail CARE monitoring protocol to new 92-93 programs.
7/13/93	.Training for contractors on CARE monitoring process.
7/16/93	.Protocol mailed for Annual Program Reports for renewal programs.
7/26/93	.Contractor responses to protocol due for new programs receiving comprehensive monitorings.
7/27/93	.Messenger review team packets for comprehensive monitoring site visits.
8/02/93	.Review teams begin site visits.
8/16/93	.Annual Program Reports due from contractors for renewal programs.
8/27/93	.Review teams complete site visits.
9/10/93	.Mail monitoring reports to contractors for responses.
9/24/93	.Finalize monitoring reports and binders for Planning Council by adding contractors' responses.
9/27/93	.Present monitoring reports and CBO responses to Planning Council.

07083BHA

DOCUMENTS DEPT.
JUL 22 1993
SAN FRANCISCO
PUBLIC LIBRARY

PLANNING TIMELINE
for
AIDS HOUSING SERVICES IN SAN FRANCISCO

July 12, 1993

June 9, 1993	.First meeting to present goals for AIDS housing services and to obtain community reactions.
June 23, 1993	.Initial Proposals to: improve client access to housing by centralizing housing information and decentralizing intake; and expand capital development capability.
July 7, 1993	.Presentation of Initial Proposal for San Francisco AIDS Housing Model. Review of programs & contracts currently held by Shanti Project. Discussion of desirable transition of Shanti housing programs & contracts consistent w/AIDS Housing Model.
July 14, 1993	.Discussion of Implementation of Centralized Information and Referral.
July 21, 1993	.AIDS Office Initial Proposal about How To Implement Transition of Shanti Housing Programs/Contracts.
August 11, 1993	.AIDS Office Initial Proposal about How To Implement Centralized Information and Referral.
September 8, 1993	.Review of Housing Needs Assessment and Proposed Action Plan. (Major Components)
October 4, 1993	.HIV Health Services Planning Council begins Reprioritization of CARE Services.
January 1, 1994	.Transition of Shanti Project's Housing Programs/Contracts.
February/March 1994	.Review of Comprehensive Housing Plan.
April/June 1994	.Submission of HOPWA Application to HUD.

T-
22
#1
7/26/93

SF

HIV HEALTH SERVICES PLANNING COUNCIL

July 26, 1993

25 Van Ness, Third Floor Conference Room

4:30 to 7:30 p.m.

Agenda

DEPOSITORY ITEM
DOCUMENTS DEPT.
JUL 22 1993
SAN FRANCISCO
PUBLIC LIBRARY

I. Roll Call

II. Review of Minutes and Agenda

III. General Announcements

IV. Training on CARE Monitoring Site Visits (4:30 - 5:30 p.m.)

V. Update on the Transition of Shanti Housing Programs

VI. Report from Monitoring Task Force

VII. Off-Site Meeting Possibilities

VIII. AIDS Office Reports
--Review of CARE-funded DPH Positions
--Review of Current AIDS Office Assessment; Research Projects

IX. Designation of Council member to HOPWA Loan Committee

X. Public Comment

DOCUMENTS DEPT.
AUG 0 5 1993
SAN FRANCISCO
PUBLIC LIBRARY

HIV HEALTH SERVICES PLANNING COUNCIL

July 26, 1993
25 Van Ness Avenue, Fifth Floor
4:30 - 6:40 p.m.

MEMBERS

Present: Pat Christen, Marcy A.Fraser, Yvonne Frazier, Barbara Garcia, Lester D. Hanson, Sandra R. Hernandez, Gerald Lenoir, Gifford S. Leoung, Steve Lew, Kent Macdonald, Scott Miller, J. B. Molaghan,Bob Nelson, Elliot S. Ramos, Steve Roger, Mike Shriver, Rita Times, Reggie Williams, Jerry Windley, Mary Jane Wood **[20]**

Absent: Estela Garcia, Jaime Geaga, Karen F. Hembry, Susan Karp, Laura Thomas

Staff Present: Sophia Chang, James Loyce, Jr., Valerie Dorr, Joseph Cecere, Mark Morewitz, Charles Brand

I. Roll Call

Roll call was taken as above.

II. Review of Minutes and Agenda

The July 12th Planning Council meeting minutes were approved, without opposition or abstentions.

III. General Announcements

Reggie Williams reported on the HRSA meeting he attended last week. HRSA is conducting a series of nationwide meetings in preparation for CARE Act reauthorization. He commended the Council on members' ability to work together cooperatively.

Last week in Washington the CAEAR (Cities Advocating Emergency AIDS Relief) Coalition vigorously lobbied Congress for Year Four CARE appropriations. To assure uninterrupted CARE funding, the CARE Act must be reauthorized by fall 1995 in order to be funded for Year Six. The Sheridan Group will calculate the cost of the reauthorization and appropriation efforts. The Council has provided the Sheridan Group with a CARE contractor mailing list. The Coalition will be asking contractors for support.

IV. Training on CARE Monitoring Site Visits

Valerie Dorr conducted the training for Planning Council members and community persons participating in CARE contract monitoring. For each site they will monitor, participants received all pertinent contracts and budgets, with any revisions, for fiscal years 1992/1993 and 1993/1994;

narrative and protocol questions; scoring criteria; and a sample report. Site visits will include client record review and AIDS Office staff have developed standard review criteria. At the time and place of the site visit, each monitor is asked to provide a completed *Confidentiality* form to the AIDS Office staff-person on the team.

Participants were urged to be on time for site visits and to contact Valerie Dorr at 554-9038 if they are delayed or if an emergency prevents their participation. Monitors were warned not to discuss monitoring information with contractors outside of the forum of the site visit. All were cautioned as to the confidentiality of monitoring information prior to the development of a written report.

Health Services staff will write the reports, which will be circulated for monitor review prior to being sent back to the contractor agency. A timely response by all monitors will allow final reports to be prepared and sent by September 10th. Final reports will thus be reviewed as part of the Council's scheduled prioritization process.

Sandra Hernandez stressed that the monitoring effort must keep sight of the intent of CARE funds: meeting the needs of persons with HIV.

Q- What is a "process goal?" A- These are delineated in the contracts. They're concerned with how programs operate, how services are provided, how clients interface with the program.

Q- Why don't monitoring visits include client interviews? A- We do so only if it is germane to specific complaints. A monitor may request to review required client satisfaction surveys. The Planning Council will be undertaking its own client satisfaction survey during the coming year.

V. Update on the Transition of Shanti Housing Programs

Sophia Chang: The AIDS Office about to put out an alternate solicitation process for congregate living and Shanti House programs and hopes to have the contract(s) certified by January. Visiting Nurses & Hospice will be awarded the Shanti 24-hour house program, on a sole-source basis. It currently holds contracts for two of the three 24-hour houses. The mechanism of transfer of housing subsidy programs is still to be determined, and will be based on further discussion of the centralized housing information and referral system.

V.a. Discussion of Potential Commitment to Multiple Year Funding

The Council discussed the difficulty of attracting serious developer interest if CARE funds are not assured on a multi-year basis. The Redevelopment Agency's housing need assessment will allow us to prioritize our housing investment and determine the amount of support services required.

The following motion was made:

> *The Planning Council sets aside Title I formula funding in the range of up to a dollar-for-dollar match of HOPWA capital funding, for a period from thirty to sixty months.*

Some members advised against being specific about the time period, until further research is completed. A friendly amendment was made, to eliminate the *"thirty [months]."* This modified motion passed by a vote of 14 in favor, 1 opposed. [Bob Nelson, Pat Christen, Gerald Lenoir, and Steve Roger abstained].

The Planning Council will set aside Title I formula funding in the range of up to a dollar-for-dollar match of HOPWA capital funding, for a period of up to five years.

VI. Report from Monitoring Task Force

Steve Nelson presented the Task Force report on strategic monitoring [copy attached].

Points raised by Council members and Health Services staff were clarified. The AIDS Office takes an active and ongoing role in contract oversight. It is misleading to give the impression that the activities described in the report constitute all of Planning Council and AIDS Office oversight. It was felt that "informal site visits" of red-flagged agencies was inappropriate. Any site visit, based on program or agency concerns, is a formal monitoring action, regardless of the scope of activity. Members agreed to eliminate the rhetorical suggestion that a response to logistical problems of monitoring would be to reduce the amount of funds requested. Programming and funding are still insufficient, and the work of the task force is part of the Council's effort to maximize resources and productivity.

A revised report, delineating several levels of site visit intensity, will be presented at the August 16 Council meeting.

The *Contractors Program Report* form was distributed [copy attached].

VII. Off-Site Meeting Possibilities

Charles Brand discussed alternative sites for Council meetings [see attached]. Council members suggested additional sites, and stressed the urgency of holding public meetings in the Castro and Tenderloin areas. All suggested sites will be checked for access, accessibility and availability.

A public meeting was scheduled for September 27, at a site in the Tenderloin.

VII. AIDS Office Reports

--Review of CARE-funded DPH Positions

--Review of Current AIDS Office Assessment Research Projects

Valerie Dorr gave a précis of all CARE-funded DPH positions. These total 103, of which 72 are filled and 20 have waivers (language, gay health, or AIDS specialization). The report will be provided at the next meeting.

The Council specified the assessment information it is requesting. It wishes to know of all AIDS Office assessment activities and research that would inform its planning process. The information will be provided at the next Council meeting.

The report *YO3 CARE Funding for POC Target Population* was distributed [copy attached].

IX. Designation of Council member to HOPWA Loan Committee

The Council designated Rita Times to serve on the HOPWA Loan Committee.

IX. A Designation of Council members to IGA Quarterly Meeting

The Council designated Mike Shriver to represent it at the IGA quarterly meeting.

X. Public Comment

There was no public comment.

The Council adjourned at 6:40 p.m.

THE NEXT PLANNING COUNCIL MEETINGS:

AUGUST 16 --- AUGUST 30

4:30 -- 7:30 p.m.

25 Van Ness Avenue -- Third Floor Conference Room

o:\wp\brand\pcl726.doc

7/30/93-11:30

DOCUMENTS DEPT.
AUG 05 1993
SAN FRANCISCO
PUBLIC LIBRARY

2

SF

6-93

HIV HEALTH SERVICES PLANNING COUNCIL

August 16, 1993
25 Van Ness, Third Floor Conference Room
4:30 - 7:30 p.m.

Agenda

I. Roll Call

II. Review of Minutes and Agenda

III. General Announcements

IV Report from Castle Rock Consulting Group
Reimbursement & Copayment Projects

V. Updated Strategic Monitoring Plan

VI. Long Range Planning Update
--Support Center
--Housing

VII. Review of Current AIDS Office Assessment Research Projects

VIII. Review of CARE-funded DPH Positions

IX. Fall 1993 Council Meeting Schedule

X. Public Comment

PLANNING COUNCIL MEETINGS IN AUGUST 1993

4:30 -- 7:30 p.m.

AUGUST 16 --- AUGUST 30

o:\07143aao.doc (3)

City and County of San Francisco

Department of Public Health

DOCUMENTS DEPT.
AUG 05 1993
SAN FRANCISCO
PUBLIC LIBRARY

DATE: July 26, 1993

TO: HIV Health Services Planning Council

FROM: Subcommittee on Strategic Monitoring

RE: Findings Concerning: Three Year Cycles for Comprehensive Monitorings, Issues Which Would Trigger Site Visits, and a Method to Arrange for Planning Council Site Visits that are not Staff Intensive.

The Subcommittee on Strategic Monitoring met on July 15 and 21, 1993, to discuss three year cycles for comprehensive monitorings, issues which would trigger site visits, and a method to arrange for Planning Council site visits that are not staff intensive. In attendance at these meetings were Bob Nelson, Kent Macdonald, Rita Times and Steve Roger. AIDS Office staff included Judith Weld, Bill Haskell and Jimmy Loyce.

Following are the findings of this subcommittee on these issues:

1. New programs (those in operation for 1 to 3 months) would receive a New Contractor's Checklist and not be comprehensively monitored.

2. All programs (those in operation for 12 to 16 months) which have not previously been monitoried would be comprehensively monitored during the summer months of July and August. This would include a response to the Contractor's Monitoring Protocol, a site visit from a technical review team, and a written monitoring report. (See below for an estimate of the number of programs this implies for upcoming cycles.)

3. During the annual summer monitoring period, approximately one-third of the remaining number of renewal programs would be comprehensively monitored. (If the number of CARE funded programs continues to increase exponentially, this number may have to be reduced from one-third to one-fourth, for a four year cycle.)

4. To accommodate this additional number of comprehensive monitorings, the preparation for this work would begin in May, protocols would be mailed out in June, and site visits would be conducted in July and August, and possibly September.

5. If a contract exhibit which has not been previously monitored is actually providing only increased capacity for another CARE funded program which has been previously monitored, this "new" exhibit would not be comprehensively monitored.

25 VAN NESS AVENUE, SUITE 500

415 - 554-9000

6. For the approximately two-thirds of the renewal programs not already identified for a comprehensive monitoring, the following five stage monitoring process is proposed:

a. All such renewal programs would respond in writing to protocol for the Contractor's Annual Report.

b. The Planning Council would establish 8 review teams of 3 persons per team. Each Council review team would be responsible for reviewing approximately one-eighth of the Annual Program Reports.

c. Each council review team would analyze the Annual Program Reports for "red flag" issues and would identify which, if any programs, should receive an informal site visit.

d. Each Council review team would identify a program for an informal site visit would then actually visit the program without conducting a formal comprehensive monitoring (no staff, no scores, no report, etc.) After the informal site visit, the Council review team may recommend that the program receive a formal comprehensive monitoring (with staff, scores and a monitoring report, etc.).

e. AIDS Office staff would coordinate a formal comprehensive monitoring for designated programs per the Council review team's recommendation. One Planning Council member from the Council review team would commit to participate on the site visit for the formal comprehensive monitoring. In this instance, the agency's board of directors would be notified.

7. Following is a rough assessment of the number of CARE funded programs. (This assessment should be recounted and confirmed by AIDS Office staff).

	FY 93-94	FY 94-95	FY 95-96
.New Programs (1 to 3 mths) (New Contractor Check List)	35	X	Y
.1/3 Renewal Programs (12-16 mths) (Contractor Monitoring Protocol)	29	35 (6 of which augment capacity of other programs)	X
.2/3 Remaining Renewal Programs (No Contractor Monitoring Protocol)	67	96	131
TOTAL	131	131+X	131+X+Y

8. The following list of programmatic "red flags" would be looked for in Annual Program Reports by the Council Review Teams:

a. Excessive staff turnover.
b. UOS/UDC provision below 70%.
c. No demonstration of resolving, or significantly progressing on prior monitoring report recommendations.
d. Significant number of client grievances.
e. Issues raised by contractor which don't seem to be satisfactorily resolved.
f. Lack of description of appropriate linkages, or lack of documentation of such linkages.
g. Achievement of process and/or outcome objectives below 50%.
h. Significant changes in client population which differs from the target population specified in the contract.

9. In regard to fiscal and administrative monitoring (which consists of board of directors, personnel and fiscal issues) the following is recommended for consideration:

a. Don't use the fiscal and administrative protocol if an agency has been comprehensively monitored within the past 12 months.

b. Don't use the entire portion of the fiscal and administrative protocol if an agency gets an A-133 audit (delete the internal controls checklist which covers items reviewed under A-133).

c. Conduct full reviews of personnel, board and fiscal items every two years.

10. The following list of administrative and fiscal "red flags" would be used as a basis to determine the need for more frequent formal comprehensive monitorings:

a. Board size substantially smaller than by-laws require.

b. Audit report is delayed more than 3 months after original due date to the AIDS Office.

c. Excessive or substantial turnover in Executive Director.

d. Audit report not conducted in compliance with A-133.

e. Agency unable to invoice the AIDS Office properly.

f. Repeated failure to resolve fiscal and administrative issues identified in last monitoring report.

This information which is related to an entire agency could be provided to Council Review Teams as part of a response to a fiscal and administrative protocol, as well as the audit report and any other supplemental material available.

11. AIDS Office staff within the Health Services Branch currently available to participate in comprehensive monitoring process include: four Program Managers; two Assistant Branch Chiefs; and one Monitoring Coordinator. Community Substance Abuse Services (CSAS), which administers its own CARE contracts, is fully responsible for monitoring its CARE funded programs. CSAS currently has one Program Manager available to participate in the comprehensive monitoring process.

12. Due to the growing magnitude of the HIV service system supported by CARE funds and the requirements of monitoring these programs, the Subcommittee on Strategic Monitoring concludes that the following strategies need to be considered:

a. Additional staff and additional Planning Council members will be needed to accomplish this workload;

OR

b. It will be necessary to expand service capacity by augmenting existing contracts, rather than by developing new services;

OR

c. It may be necessary to not accept additional funding for which inadequate administrative support is available.

DOCUMENTS DEPT.
AUG 0 5 1993
SAN FRANCISCO
PUBLIC LIBRARY

AIDS OFFICE
Health Services
July 1993

ALTERNATE SITES FOR COUNCIL MEETINGS

Line	*Frequency at 7:30 p.m.*	*Accessible Sites*	*Address*
BART		Downtown Continuation HS	110 Bartlett
		City College (via K)	50 Phelan Av
		Mission Neighborhood Center	362 Capp
M	12 *mins*	S.F. State University	1600 Holloway Av
		City College (via K)	50 Phelan Av
K	12 *mins*	City College	50 Phelan Av
J	12 *mins*	City College (via K)	50 Phelan Av
		Mission HS	3750 - 18TH
15	15 *mins*	City College	50 Phelan Av
31 (to)	10 *mins*	George Washington HS	600 - 32nd Av
38 (from)	9 *mins*		

Please contact Charles Brand (554-9549) if you know of other wheelchair-accessible sites, close to public transportation that runs frequently and can accommodate wheelchairs at the nearest stop.

carelog2.doc

Y03 CARE Funding for POC Target Population

7/7/93

FUNDS	AGENCY	SERVICE	POC Targeted Programs	POC Agency Programs
Case Management				
F	A.I.D.S.	Case Management	$76,938	$76,938
F	American Indian AIDS Institute	Case Management	$35,490	$35,490
F	GCHP	Case Management	$23,661	$23,661
S	GCHP/FTFA	Client Advocacy	$81,902	$81,902
F	Instituto Familiar de la Raza	Psychosocial Support	$72,802	$72,802
S	San Francisco AIDS Foundation	Case Management	$109,203	
F	San Francisco AIDS Foundation	Case Management	$76,897	
S	SF Clinic Consortium	Clinical Case Management	$92,522	
S	Tenderloin AIDS Resource Center	Brokerage Case Management	$64,779	$64,779
S	Westside	Nursing Case Management	$90,887	$90,887
	Total POC Contracts		$725,081	$446,459
	Total Case Management Contracts (not including DPH)		$1,165,076	$1,165,076
	Percentage of Total Case Management Funds		62%	38%
Housing				
F	A.I.D.S.	Housing Mgt./Case Mgt.	$179,423	$179,423
S	Black Coaliton on AIDS	Transitional Housing	$248,196	$248,196
S	Haight Ashbury Free Clinics	Res. SA for Afri. Am. Men	$75,000	
S	Haight Ashbury Free Clinics	Res. SA for Afr. Am. Women	$244,747	
S	Walden House	Long Term Res. Treatment	$233,325	
F	Walden House	Sub. Abuse Treatment	$218,369	
	Total POC Contracts		$1,199,060	$427,619
	Total Housing Contracts (not including DPH)		$4,151,075	$4,151,075
	Percentage of Total Housing Funds		29%	10%
Other Health Care				
S	Bayview Hunter's Point Foundation	Other Primary Care	$93,728	$93,728
S	Mission Neighborhood Hlth Ctr.	Nutritional Counseling	$49,502	$49,502
F	Westside	Home Health Care	$100,466	$100,466
	Total POC Contracts		$243,696	$243,696
	Total Other Health Care Contracts (not including DPH)		$3,572,146	$3,572,146
	Percentage of Total Other Health Care Funds		7%	7%
Primary Care				
F	18th Street Services	Sub. Abuse Counseling	$158,552	
F	A.I.D.S.	Mental Health/Sub Abuse Srvces	$124,736	$124,736
S	American Indian AIDS Institute	Crisis Intvntn/Mental Health	$26,125	$26,125
S	Baker Places	Med. Term Res. Treat.	$228,015	
F	GMOC/EACH	Com. Events/Indiv. Treat. Adv.	$163,804	$163,804
S	Instituto Familiar de la Raza	Psychotherapy Services	$36,401	$36,401
S	Iris Center	Outpatient Sub. Abuse Treatment	$207,629	
S	Iris Center	Res. Sub. Abuse Treatment	$270,313	
S	Mission Neighborhood Hlth Ctr.	Clinical Trials Advocacy	$38,503	$38,503
S	SF Clinic Consortium	Primary Medical	$327,608	
S	UCSF Sub Abuse Tx @ SFGH	Sub. Abuse Treatment	$122,672	
S	Westside	Residential Care AIDS/MH	$313,500	$313,500
	Total POC Contracts		$2,017,858	$703,069
	Total Primary Care Contracts (not including DPH)		$7,634,026	$7,634,026
	Percentage of Total Primary Care Funds		26%	9%

OLD=New program in Y03

Y03 CARE Funding for POC Target Population

7/7/93

FUNDS	AGENCY	SERVICE	POC Targeted Programs	POC Agency Programs
Psychosocial				
F	American Indian AIDS Institute	Practical/Emot. Sup.	$40,554	$40,554
F	American Indian AIDS Institute	Case Mgt	$35,887	$35,887
F	Bar Association of SF	Legal Service	$35,303	
S	Bayview Hunter's Point Foundation	Vol. Training/Emot & Practical Sup.	$107,239	$107,239
F	Bridge for Kids	Respite Child Care	$51,684	
F	Filipino Task Force on AIDS	Translation Services	$26,125	$26,125
S	**GCHP/FTFA**	**Client Advocacy/Volunteer**	**$66,662**	**$66,662**
F	National Taskforce on AIDS	Emotional Support Groups	$97,375	$97,375
S	Shanti Project/Crossings	Emot. Support/Vol. Recruit./Van	$229,422	
F	Shanti Project/Crossings	Emotional Support	$241,500	
F	Tenderloin AIDS Resource Center	Emotional Support	$74,454	$74,454
	Total POC Contracts		$1,006,205	$448,296
	Total Psychosocial Contracts (not including DPH)		$1,590,172	$1,590,172
	Percentage of Total Psychosocial Funds		63%	28%
TOTAL FUNDING				
	Total POC Contracts		**$5,191,900**	**$2,269,139**
	Total Contractual Services		**$18,089,362**	**$18,089,362**
	Percentage Of POC Funds		**29%**	**13%**

BOLD=New program in Y03

o:POCSER3

DEPARTMENT OF PUBLIC HEALTH -- AIDS OFFICE
HEALTH SERVICES BRANCH
CONTRACTORS PROGRAM REPORT
July 12, 1993

DOCUMENTS DEPT.
AUG 0 5 1993
SAN FRANCISCO
PUBLIC LIBRARY

SECTION I. PROGRAM REVIEW

Your answers to the following questions for each CARE funded contract exhibit (or MOU attachment) will comprise your end-of-year program report and should highlight any changes or updates since the program's last monitoring site visit. **Please refer to your contract when answering these questions.** [Note: All questions with an asterisk refer to cultural competency. Please refer to note at the end of the document.]
This document will become a public report at the time it is submitted to the AIDS Office.

PROGRAM SERVICE INFORMATION

A. Contract Compliance

1. **Please state each process and outcome objective and your success in meeting each objective. For each item in your Project Timeline, indicate the date on which the item was completed.**

Please provide a candid analysis of your success in meeting objectives and keeping to the timelines established in your exhibit. Please describe any action taken to address problems or delays in meeting objectives and keeping to timelines. Please be brief.

2. **How do you count and record units of service and unduplicated clients?**

Describe your system for tracking UOS and UDC. Please include who is responsible for recording and reporting UOS/UDC. How frequently does recording/reporting occur. In what format are UOS/UDC recorded (eg. computerized, manual, client file, etc.). How do you separate UOS/UDC by exhibit?. How do you separate a new client from an old client in tracking unduplicated clients?. Attach any appropriate forms.

3. **Are you on target in meeting your projected UOS/UDC as specified in the UOS/UDC timeline in your exhibit? If not, why not? List projected and accomplished UOS/UDC on the enclosed forms by month beginning 5/1/92 for formula exhibits and 7/1/92 for supplemental exhibits. All data should be through 6/30/93.**

4. **What are the demographics of unduplicated clients served? Please list exhibit statistics from 5/1/92 for formula exhibit and 7/1/92 for supplemental exhibit through 6/30/93 (use form attached).**

B. Program Staffing

1. **Please provide current program staff (not only those funded by this exhibit) on the enclosed demographic form. Please complete a separate form for volunteers.**

Utilize the form attached to provide staff and volunteer information

2. What is your current ratio of direct service providers (including volunteers) to clients (all staff, regardless of funding source)? Is this staffing level adequate? If not, please indicate what staff changes might be necessary.

What is the overall caseload of your staff? Are they able to provide appropriate quality service with this caseload? Do you have the right mix of staff for the volume of clients being seen in various service areas within your exhibit? What changes are needed? Can you reallocate staff within the exhibit?

3. **What has been your exhibit program staff turnover since 5/1/92 for formula exhibits and 7/1/92 for supplemental exhibits? List each position that has been vacant and the period of time the position was vacant. Describe reasons for staff turnover.**

How many staff (employees, not FTE) have left the exhibit program since the start of the program (the program start may precede the start date of this exhibit period). How long did they remain an employee? Do you do exit interviews to find out why people are leaving? What reasons are they giving? Are they burned out, overworked, under employed for their skill level?

4.* **Describe initial and ongoing training activities undertaken during the FY 1992-93 contract year. Please include information on who provided the training, how it was done/what type, and any specific cultural competence trainings. Did your agency provide any formal cultural competency training for staff and volunteers?**

What initial and ongoing training is provided? Is training done in-house or do you send employees to meetings to receive training? Is training experiential or does it mean reading procedure manuals? How does your agency address the issue of cultural competency training? For community of color agencies, how do you address cultural competency beyond ethnicity, for example working with women, differently abled, subgroups within cultures, etc.?

5. **Please provide an agency organizational chart indicating all program staff relationships within the agency, and for funded program staff, names of staff, job title, percent FTE, licensure (where appropriate) and level of professional training.**

Please provide an organizational chart identifying and naming funded staff as requested.

C. <u>Client Services</u>

1. **Are there other populations also being served/seen that weren't originally targeted? If yes, how has this changed your program objectives?**

Some programs may be seeing clients outside their exhibit target population. Does the presence of these non-targeted individuals result in a change in how your program is presented or in the objectives of the program? How?

2. What are your admission criteria? Describe your program requirements for documentation of HIV/AIDS status, income and residency. How do you collect and verify this information?

3. **Does your agency maintain a client waiting list for this program? If so, how many are on that list? How long is the average wait to enter your program? What specific issues influence the waiting list?**

Describe how you manage your requests for service. How do you assure that clients who are unable to receive service at your agency receive service elsewhere? Do you offer special programs for people on the waiting list? Why is there a waiting list for this service?

Program Management and Evaluation

1.* **Briefly describe your service delivery model in terms of cultural competency.**

Explain how your model works best for your community or target population.

2. **What are your program's strengths and areas needing improvement?**

Provide a candid assessment of program strengths and areas where improvement is needed. How do you go about making those improvements?

3. **Describe the program evaluation activities that have occurred and the results of the evaluation process since 5/1/92 for formula exhibits and 7/1/92 for supplemental exhibits.**

Include a description of client feedback mechanisms used by your program.

4. **What are your program's strengths and areas needing improvement in relation to cultural competency?**

Where could your agency improve in the area of cultural competency? Very few agencies are truly culturally competent in all areas that may be appropriate. How do you address problems when they are identified? Please refer to the footnote defining cultural competency on the last page, and be sure to address differently abled populations.

5. **Please describe your success in implementing the recommendations contained in your October 1992 monitoring report.**

Please report on your progress for each recommendation.

E. Community Relations

1. **What are the primary relationships (describe no more than three) that this exhibit program maintains with other programs in your own agency and/or in the community? (Please attach copies of any Memoranda of Understanding, Subcontracts or Letters of Cooperation).**

Describe the nature of the relationships and the names of agencies with which you work most closely.

2. **Is your program site close to your client catchment area? What are your hours of operation? Have they changed since your last monitoring visit?**

Where do your clients live? Can they access your program easily?

3. **How do you attempt to make your program's site (physical plant) welcoming and/or appropriate to the target population? How do you address issues of literacy, language and differently abled clients?**

Describe how you have adapted your site to make it welcoming to clients. What makes clients comfortable in your setting?

4. **Please describe how you provide outreach to the community about your program(s) and service(s)? Attach outreach material specific to this program.**

Describe the manner in which you inform the community about your service. Describe the frequency with which outreach occurs.

F. Quality Assurance

1. **What information do you keep in a client record and how is it updated? Who enters information into the client record? (Please attach a sample client record.)**

Describe the contents of the client record, who completes it and who updates it. Is there specific information you do not put in the record? Where would this other information be kept?

2. **How do you conduct record reviews? Who performs them and is there a sign off procedure? Provide specific details on procedures, frequency, the participants involved and their responsibilities.**

3. Describe the outcomes of quality assurance activities since 5/1/92 for formula exhibits and 7/1/92 for supplemental exhibits.

What are the results of your qualitiy assurance activities? How have you utilized this information?.

G. Policies and Procedures

1. **Please provide any changes or updates to your program policy and procedure manual.**

2. **Please provide a copy of your agency policy on universal precautions. Are staff, volunteers, and clients receiving annual tuberculosis skin testing? If so, how are the results documented?**

3. **What is your policy and procedure regarding confidential information and access to client records? How is confidential information maintained and stored?**

Attach a copy of your program/agency policy and procedure. At minimum, describe your current procedure(s) and who has access to confidential information. If you computerize client information, explain your computer back-up and password/security systems. Please describe your building/office security procedures.

4. **How do you provide client rights information to your clients?**

Describe the process by which clients are informed of their rights. Attach a copy of patient/client rights information if available.

5. * **What is your client grievance procedure, how is it used, and how many times has it been used since 5/1/92 for formula exhibits and 7/1/92 for supplemental exhibits? What were the results?**

Who in the agency is responsible for hearing and responding to grievances? How are clients and staff informed of the client's grievance procedure? How many times has the grievance procedure been used by clients of this exhibit service?

6. **Describe how service and discharge plans are designed and used for each client. Who develops the plans? Are they kept in the client record? How often are they updated? Does the client participate in the development of his/her service plan? Does the client sign the service or discharge plan?**

What determines the service or discharge plan content for a client? How is information necessary to complete a service or discharge plan obtained? How, why, and when are plans revised? Describe the level of client involvement in developing the actual components of the service plan. Do clients indicate their acceptance of the plan by signing the plan?

7. What unmet client needs related to your program have been identified?

This information will be used for planning purposes. No rating will be affected by your response.

8. **How can the AIDS Office assist you in improving program services for your clients?**

**Please note that cultural competency refers to an agency's ability to respond in an appropriate, accessible, equitable and sensitive manner to varied populations. Examples of groups for whom culturally competent services are an issue include: ethnic and racial communities, the emotionally disturbed, transgender populations, youth, women, the differently abled, lesbians/gays/bisexuals, the indigent, and substance using groups.*

Attachments to be provided with the program report:
Client/Patient rights information
Client Grievance procedure
Program policy and procedure manual updates
Universal precaution procedures
Demographic form for clients, staff and volunteers
UOS/UDC performance forms
All MOUs, Letters of Cooperation and Subcontracts applicable to the program
Organization chart

22
2
11493
SF

HIV HEALTH SERVICES PLANNING COUNCIL

August 16, 1993
25 Van Ness Avenue, Fifth Floor
4:30 - 7:00 p.m.

MINUTES

DOCUMENTS DEPT
AUG 26 1993
SAN FRANCISCO
PUBLIC LIBRARY

MEMBERS

Present: Marcy A. Fraser, Barbara Garcia, Estela Garcia, Lester D. Hanson, Sandra R. Hernandez, Gerald Lenoir, Gifford S. Leoung, Kent Macdonald, J.B. Molaghan, Elliot S. Ramos, Steve Roger, Mike Shriver, Reggie Williams, Mary Jane Wood.

Absent: Pat Christen, Yvonne Frazier, Jaime Geaga, Karen F. Hembry, Susan Karp, Steve Lew, Scott Miller, Bob Nelson, Rita Times, Jerry Windley.

Staff Present: Sophia Chang, Valerie Dorr, Herman Levias, Charles Brand

Consultants: Miles Amen, Don Martin.

I. Roll Call

Roll call was taken as above.

II. Review of Minutes and Agenda

The July 26th meeting minutes will be reviewed August 30th. No quorum was present when this item was reviewed.

III. General Announcements

Mike Shriver observed that there was a move afoot within the reauthorization of the CARE Act to join Titles I and II, and channel all funds through the states. The general reaction was that this would inflate administrative overhead, compound review, and result in less funding for direct client services.

IV. Report from Castle Rock Consulting Group: Reimbursement & Copayment Projects

Handout: Castle Rock Consulting Group, *Final Report: Copayment & Medi-Cal Revenue Enhancement Project*, August 16, 1993. [For a copy, call Keiko Kim at the AIDS Office, 554-9116].

Miles Amen of Castle Rock distributed and discussed the *Final Report*. The first review of client copayment systems included a questionnaire to CARE-funded agencies. Two-thirds of CARE providers responded, a high rate. The data on agency size is based on the statement of total income in the 1993 CARE contracts. Providers with some copayment system in place were more positive about such systems. They were larger organizations, usually providing health care or residential services -- the group for whom a copayment system is most feasible.

Organizations with a poorer clientele and services that do not lend themselves to copayment, were least positive.

The consultants felt that a mandated centralized copayment system would not work well. Providers will resist participation unless they feel that their efforts will be rewarded. Participation should be voluntary, with the AIDS Office establishing guidelines.

Castle Rock discussed the AIDS Waiver Program with the State as well as Westside, a San Francisco contractor. The program has undersubscribed and could meet the specific needs of persons with significant care needs. It can provide significant new revenues. To promote its goal of minimizing inpatient care, it reimburses many services otherwise excluded, such as case management, attendant care, homemaker services, environmental modifications, home delivered meals and non-emergency transportation. . Statewide participation is limited to 2,200, but only 1,200 are currently enrolled. The State wishes to increase enrollment and will help localities implement it. Possibly $15 million in additional reimbursements could be gained systemwide for AIDS services, with varying implementation costs dependent upon the program model. Either model would require initial capital investment for startup. This would help reduce reliance on other funding sources.

The State encourages contractors to have multiple subcontractors, so that patients may have a choice of providers. Few if any contractors deliver the whole panoply of services. Some are allowed to provide direct services, even exclusively. [Sandra Hernandez: No California Waiver Program contractor offers *all* services.] Reimbursement projections for multi-providers and sole providers [see *Final Report*, pages 42-43], indicate that only the latter will enjoy a profit, due to lower administrative overhead and greater ability to control cost. The projections do not include indirect costs.

Dr. Hernandez and others discussed whether the best approach would be a new program that the Council and AIDS Office designed with state approval. Current models are problematic, and no data to date have shown the State program to be cost-effective. Dr. Chang noted that managed care might render a new program obsolete. The State has recently applied to and been approved by the federal government for a renewal of the Waiver Program.

Dr. Hernandez stressed that few agencies were capable of implementing a Waiver program. Community clinics are less experience in providing home care. Although the figures used in the *Report* are conservative, they are still soft, still guesses. Miles Amen still suggested that the Planning Council give priority to the Waiver Program, and discuss it with the State and the few organizations that could take it on.

Other points raised were:

- Doesn't the deflection of clinical nurses from direct services to reimbursement sign-off, indicate structural weakness? How could such a model be cost-effective?

- Can nursing units implement all these programs?

- Won't "fee for service", versus capitation, drain profits?

- The *Report* does not look at other Medi-Cal subcontractor systems, such as San Mateo County's county-operated health system, with its care management and capitated reimbursements.

Q.- Will the Council push copayment?
A.- CARE grantees are required to collect client copayment. This is a complex situation, because of the preponderant attitude of "entitlement" among persons with A.I.D.S.: that all services should be free. HRSA is sensitive to this and has not pushed the requirement.

Q.- Where can copayment be implemented most readily?
A.- Among providers of direct services. It would be most difficult for those providing confidential or informational services.

Q.- Why is Medi-Cal Waiver program underutilized?
A.- It has not been widely disseminated. Also, it poses major administrative hurdles for small organizations or those with less developed accounts-payable systems.

Q.- Isn't there a bias against patient access when working through a home care agency?
A.- The clinics usually refer patients to home-care agencies.

Q.- Why does the *Report* refer only obliquely to SB910 [in the Appendix]? It could provide significant revenue possibilities for AIDS contractors.
A.- This study was oriented toward CBO's, not health departments.

Dr. Gene Copello noted that some San Mateo CBO's were eligible for SB910, which reimburses more readily than the Waiver Program does. Dr. Hernandez said that San Francisco had not yet extended SB910 reimbursement to its AIDS contractors, but should. SB910 would allow the State to be billed for a substantial sum that now comes from Ryan White and the General Fund.

Mary Jane Wood asked if there would be a SB910 presentation. Dr. Hernandez mentioned that the Health Department is considering support of a pilot program to train one contractor in SB910 billing.

The Council discussed how to proceed, now that the *Final Report* has been received. Dr. Chang noted that the Waiver Program had some favorable and negative aspects, and the Council should decide whether this to pursue it further. Dr. Chang will approach the State as well as potential providers, to determine if it is a viable approach.

There was general agreement that the *Final Report*, with its eloquent analysis and description, was an important contribution.

The following motion was made and passed, without opposition or abstention:

A) **The Planning Council will review the *Final Report* and consider its recommendations when prioritizing 1994/1995 Ryan White expenditures.**

V. Updated Strategic Monitoring Plan

The updated *Strategic Monitoring* report of August 16, 1993, was distributed to the Council [copy attached]. Valerie Dorr showed how it incorporates the changes specified by the Planning Council on July 26. Participation by the appropriate Health Services Branch Program Manager is included in § 6b, and the different types of reporting and monitoring situations are further defined. The number of site visits will at least double, although some would focus on specific issues that were noted when the annual report was reviewed. For instance, a team might inquire about heavy staff turnover, or observe how an agency deals with units-of-service or unduplicated-client reporting.

Q.- What is the purpose of "informational" visits?
A.- They would be at the Planning Council's option, time and interest permitting. Motives include familiarization with a program, study of a novel program approach, or encouragement of excellent performance.

Q.- Do §9a and §9c (fiscal and administrative monitoring) prevent some of the recent problems with agencies?
A.- Dr. Hernandez replied that §9c does.--Valerie Dorr felt that §9a also does -- *if* the agency reports accurately. Further, Shanti did not file an audit report meeting A133 requirements, which it was required to do.

Q.- Why is §12c unchanged?
A.- The subcommittee listed every possible response. While this might seem to imply that San Francisco is supersaturated with grant funds, the intention is to emphasize that more staff time is needed for monitoring. It is made within the context of serious discussions on increasing the percentage of funds that can be used for administrative overhead.

Several Council members still felt that §12c was too negative and unclear. Further, sections "a", "b" and "c" were not mutually exclusive. The Council will discuss the *Strategic Monitoring* report further on August 30.

VI. Long Range Planning Update

Planning: Sophia Chang reported that client and service assessments are proceeding satisfactorily. The Support Center began the focus groups last Friday, and several more will be held this week. Many AIDS providers have responded positively. The client assessment is exceeding our expectations. To date, HSB has encoded more than 1,800 responses.

Housing: Valerie Dorr reviewed the intensive HSB activity in this area. An alternative method of solicitation was issued for housing services previously contracted to Shanti. Staff were meeting with different agencies, providers and developers. The focus is on how to develop more housing. Semi-monthly meetings with providers have augmented our information and enhanced our perspective. Two weeks ago, HSB staff met with case managers regarding centralized intake and referral. A proposal for centralized intake will be issued the end of October. Providers recommend that when a new system commences, all clients be taken off current wait lists and put into a centralized list. HSB is currently seeking clarification from the Housing Authority about regulations that may affect intake. HSB and Substance Abuse Services are discussing links between central information and referral, and Substance Abuse residential treatment programs. Meetings with hospice and skilled nursing services will focus on the problem of patients being discharged without housing or support services.

VII. Review of Current AIDS Office Assessment Research Projects

Research project descriptions were distributed to Council members. [See Attachment.]

AIDS Office Health Services Branch Research/Planning Activities

1. *Client-Based Needs Assessment Survey*
2. *Service System Overview*

Research Branch Activities -- San Francisco AID Office

1. *San Francisco City Clinic Cohort Study (SFCCC)*
2. *Incidence/ Vaccine Feasibility Study*
3. *Health Access Study*
4. *Care Evaluation Project*

Current Research and Assessments Conducted by the AIDS Office Research Branch

1. *CTRPN-EI*
2. *Evaluation and Behavioral Research*
3. *HIV Prevention Needs Assessment*
4. *State-Funded Program Performance Evaluation*

Current or Planned Surveillance Branch Research Activities

1. *AIDS Case Projections*
2. *Survival Analysis of AIDS Patients*
3. *National Death Index (NDI) Match*
4. *AIDS Case Matching with the Northern California Cancer Center*

HIV Seroprevalence Activities

1. *Regional Young Men's Survey (YMS)*
2. *Women's Survey*
3. *HIV Risk Assessment An Analysis of Gay and Bisexual Men*
4. *Evaluation of HIV Testing and Counseling Services at a Sexually Transmitted Disease Clinic*
5. *Trends in HIV Infection among Clients at a Sexually Transmitted Disease Clinic*
6. *Survey of Risk Behaviors among Homeless and Runaway Youth in San Francisco*

VIII. Review of Care-funded DPH Positions

Valerie Dorr discussed the report *CARE-Funded DPH Personnel -- FY 1993/ 1994*, prepared at the Council's direction [copy attached]. Dr. Hernandez noted that no information is current for long, since displacement and reassignment of staff continues. Frozen requisitions will be released soon, since the Board of Supervisors passed the small business tax increase today. The Layoff Task Force has been advised of the necessity of phasing in personnel changes in a single office, to avoid wiping out all knowledge in a single day. Business Services is particularly affected. Many of the new staff are from San Francisco General Hospital administration. They bring important new talents and expertise, but have much detail and process to learn. Last Friday the impact of staff changes was discussed at great length last Friday with the Health Services Advisory Committee. The bottom line is that good communication and timely performance will mitigate most effects. Further, the AIDS Office is closely monitoring salary savings from Formula and Supplemental funds to maximize their utilization.

Q.- Will this affect monitoring?
A.- Strategic Monitoring addresses this issue. We have completed the bulk of this year's site visits.

IX. Fall 1993 Council Meeting Schedule

The public comment meeting will be held on September 27th at Glide Memorial United Methodist Church, from 4:00 - 7:00 p.m.. Council members should plan on remaining until 8:00 p.m..

X. Public Comment

There was no public comment.

The Council adjourned at 7:00 p.m..

NEXT PLANNING COUNCIL MEETING:

Monday -- August 30, 1993 -- 4:30 - 7:30 p.m.

25 Van Ness Avenue -- Third Floor Conference Room

o/wp/brand:/pcl816.doc

F
22
#1
8/30/93

'SF

HIV HEALTH SERVICES PLANNING COUNCIL

August 30, 1993

25 Van Ness Ave., Third Floor Conference Room

4:30 to 7:30 p.m.

DOCUMENTS DEPT
AUG 26 1993
SAN FRAN
PUBLIC LIBRA

AGENDA:

I. Roll Call

II. Review of July 26 and August 16 Minutes and Agenda

III. General Announcements

IV. Monitoring Task Force Report Review

V. Discussion of Castle Rock (Reimbursement Consultant) Recommendations on Medi-Cal Waiver Program

VI. Agenda for September 27th Public Hearing

VII. Discussion of Planning Council Membership

VIII. Update on Needs Assessments

IX. Public Comment

o/wp/brand/pcagend.doc

DOCUMENTS DEPT.
SEP 1 0 1993
SAN FRANCISCO
PUBLIC LIBRARY

HIV HEALTH SERVICES PLANNING COUNCIL
August 30, 1993
25 Van Ness Avenue, Third Floor
4:30 - 7:30 p.m.

MEMBERS

Present: Marcy Fraser, Yvonne Frazier, Barbara Garcia, Estela Garcia, Jaime Geaga, Sandra Hernandez, Susan Karp, Gifford Leoung, Steve Lew, Kent Mcdonald, Scott Miller, Bob Nelson, Elliot Ramos, Mike Shriver, Laura Thomas, Rita Times, Reggie Williams, Jerry Windley, Mary Jane Wood.

Absent: Pat Christen, Lester Hanson, Gerald Lenoir, J.B. Molaghan, Steve Roger.

Staff Present: Sophia Chang, Bill Haskell

I. Roll Call
Roll call was taken as above.

II. Review of Minutes and Agenda
The minutes of July 26, 1993 were reviewed and approved, with Estella Garcia, Rita Times, Laura Thomas, Jaime Geaga and Scott Miller abstaining. The minutes of August 16, 1993 were reviewed and approved, with Rita Times, Laura Thomas, Scott Miller, Bob Nelson, and Jaime Geaga abstaining. The agenda of August 30, 1993 was approved.

III. General Announcements
Mike Shriver announced that the Senate mark-up on the Labor, Health and Human Services bill for CARE funding will take place during the second week in September. He anticipates that at least $133 million new dollars will be maintained, which the House of Representatives provided to CARE Title I, with a push for an increased allocation to CARE Title II. The CAEAR Coalition will be lobbying in Washington, D. C. on September 7, 8 & 9, 1993, including meeting with Christine Gebbe. On September 12, 13 & 14, 1993, the CAEAR Coalition and all the national organizations will be lobbying for increased allocations for the HOPWA program.

San Francisco has hired a federal lobbyist, Marilyn Barrie Thompson, for health care related issues. She was informed of the importance of HIV/AIDS issues during an initial meeting with Mike Shriver, Reggie Williams and representatives from the San Francisco AIDS Foundation and the AIDS Legal Referral Panel. Another meeting will take place within a half a year.

In regard to the Health Outreach Team, Mitchell Katz, MD, Director of theDPH AIDS Office, has formally recommended that the organization be placed on probation. The Subcommittee on Evaluation will meet on the afternoon of September 13, 1993 to review this issue. The President of the Board of HOT and the Executive Director will be invited to speak at the Subcommittee

meeting. They will also be invited to speak later the same day to the Planning Council, which is also meeting on September 13, 1993.

A CARE Title I grantee meeting will be held in Washington, D.C. on November 15, 16 & 17, 1993, sponsored by HRSA. AIDS Office staff will be in attendance. HRSA will pay for two Planning Council members who desire to attend. Those who would like to go to this meeting should contact Sophia Chang and inform her of their interest.

IV. Monitoring Task Force Report Review

Sophia Chang announced that additional minor additions and corrections need to be made to the Monitoring Report Task Force report. She also wants to reformat the document, which will be sent out with the minutes of this meeting. The revised draft will be on the agenda of September 13, 1993 for final approval. This document will be mailed out separately.

V. Discussion of Castle Rock (Reimbursement Consultant) Recommendations on Medi-Cal Waiver Program

The Planning Council requested that the AIDS Office staff formally inquire at the State Office of AIDS about the timing of the application for the Medi-Cal Waiver program, whether they face any problems in preparing this application, and if a letter of support from San Francisco's HIV Planning Council would be helpful. Staff will make this inquiry and prepare a memo explaining its findings.

Estela Garcia stated her belief that the Medi-Cal Waiver program previously operated out of the AIDS Office (now operated by Westside Community Mental Health Services) presented a lot of problems as well as liabilities. She also believes the program has limitations on services to clients.

Sandra Hernandez stated that she recognized the limitations of the program as it is currently designed. However ,she said that discussions should proceed about the possibilities of modifiying the program design so that more service delivery could be made available. The question that she is considering is whether it is worth taking the time to prepare an application to the State which would present a variation on the current program design. To do this would require Westside's participation. If the application were to be awarded, then San Francisco could draw down the Medi-Cal Waiver dollars to cover the cost of needed home care services. Such a modification in program design could result in additional attendant care hours which are needed.

Sophia Chang noted, however, while additional attendant care may be obtained, it would have to be within a case management model. Dr. Chang will investigate with the State Office of AIDS the potential of modifying the program model. However, if a new model is needed,she noted that the Council will probably not be able to invest CARE funds in such a program this year.

Sandra Hernandez recommended that staff meet with Janet Nassar to discuss Westside's experience with the Medi-Cal Waiver program and to determine this agency's need for additional attendant care.

Mary Jane Wood recommended that SB 910, as an alternate source of revenue, would be eligible to cover the cost of services currently supported by the General Fund (but not covered by CARE). AIDS Office staff is investigating the potential of SB 910 as a revenue source for services supported by the General Fund, which may allow redistribution of General Fund dollars.

Sandra Hernandez stated that the next year will present another diffucult budget year. SB 910 will need to be pursued as a potential new revenue source in the coming year, in order to consider a broader revenue package.

Kent Macdonald requested an educational session to explain definitions, background and history of reimbursement strategies such as the Medi-Cal Waiver program. Sophia Chang said that background documentation prepared by Castle Rock is available for the Council's review. Reggie Williams noted that not all Council members are familiar with the terminology used at meetings about reimbursement, including Medi-Cal Waiver, Medi-Cal, Pilot Care, and Managed Care. Sophia Chang said that she could explain these terms to the Council. She noted that the initial impetus to do the reimbursement study was that the Council, in determining how to use CARE funds, wanted to investigate other revenue sources and how to maximixe these sources.

Estala Garcia and Gifford Leoung stated that revenue enhancement options other than the Medi-Cal Waiver program should be investigated to support HIV health care services. Mary Jane Wood raised the option of the regular Medi-Cal program as a viable revenue source. Sophia Chang stated that the rate of return for the additional work to maximize reimbursement for all services currently billed may be too costly to be worthwhile. However, the question remains if all eligible individuals are being identified so that Medi-Cal could be billed for reimbursable services, especially by community-based service providers.

Sophia Chang noted that the Council continues to fund the Reimbursement Unit in the Health Services Branch of the AIDS Office, which could pilot a Medi-Cal trouble-shooting service for community-based service providers, to follow up on applications and ensure that benefits are actually obtained for reimbursable services.

VI. **Agenda for Planning Council Public Hearing on Service Needs (September 27, 1993)**
The Planning Council public hearing on HIV service needs is scheduled for Monday September 27, 1993, from 4:00 p.m. to 7:00 p.m., at the Glide Memorial Church. However, Council members should schedule from 4:00 p.m. to 8:00 p.m.to allow time for late arrivals. The hearing will be advertised in the Chronicle/Examiner, El Tiempo, the Bay Times, Asia Week, the Independent, the Bay Area Reporter, and the Street Sheet. Public service announcements will also be scheduled. This is the public hearing prior to the next prioritization of of HIV services which will occur early October. A signer for the hearing impaired, and Spanish and Cantonese language translation will be made available. Gifford Leoung and Jerry Windley will not be present. Speakers will be limited to three minutes for each presentation. Speakers will address their three priority needs and offer opinions about the best models or programs for how these needs would best be met. Comments can be oral or in writing. Estela Garcia and Steve Lew will chair this meeting. A copy of the notice for this public hearing will be included with the minutes of this meeting. (See attachment)

VII. Discussion of Planning Council Membership

Sandra Hernandez announced that she and Reggie Williams have decided to step down as co-chairs of the Planning Council. Dr. Hernandez will be resigning from the Council, but Reggie Williams will remain as a regular Council member.

At the same time that new leadership is considered, new membership on the Council should also be considered. The Mayor's Office has been notified of the need to change co-chairs. Historically, the co-chairs have been filled by the a DPH representative and a community representative. However, this arrangement has been informal and not included in the By-Laws. In additon, effort has been made to have communities of color represented, the gay and lesbian communities represented, and the infected and affected communities represented. It is important to note that co-chairs do not vote on any issues.

The Mayor and Supervisor Kauffman have put together an HIV Task Force which will focus on issues different from those deliberated by the Planning Council. The focus of the Kauffman Task Force's activities will be Dr. Hernandez' responsibility. Given that this body has a one year life span, Dr. Hernandez will step down to work with this Task Force.

Reggie Williams believes that a co-chair of the Council should be present as much as possible. Because of his travels, he has been unable to do this. For this and other reasons, Reggie Williams must step down as co-chair, but will remain on the Council.

Dr. Hernandez mentioned that one role of the co-chairs has been to speak to the media, and to work with Sophia Chang and her staff on all issues related to CARE funding and HIV services being addressed by the Council.

In regard to Council membership, historically there has been Health Commission membership. The Commission is familiar with the work of the Council. It is possible to pursue with the Mayor the appointment of a Health Commissioner on the Council if that is desirable. By CARE Title II standards, the Council requires representation of State/federal-supported home and community-based care providers and the incarcerated. Council members also expressed the feeling that HIV infected individuals and youth should be more broadly represented.

Steve Lew stated, in regard to the role of the co-chairs, the Council may need to further define their role, aside from public spokespersons. He is concerned only with gender parity and HIV representation for the co-chairs; other representation can be addressed through general Council membership. The Council may also want to designate alternate co-chairs.

The Planning Council thanked Sandra Hernandez and Reggie Williams for their excellent work and leadership as co-chairs. (OVATION!)

The following motion was passed without opposition or abstention:

The Planning Council co-chairs should have representation from the DPH AIDS Office and the community, at least one of whom is HIV infected. Alternate co-chairs should also be selected.

The By-Laws were briefly reviewed. It was agreed that these By-Laws should be amended to reflect the above motion concerning DPH and community representation within the co-chairs.

Dr. Hernandez said that discussion has taken place within DPH concerning the best individual to serve as the Planning Council co-chair. Sandra Hernandez stated that James Loyce has been generally considered to be the best qualified individual to assume this role. Should he be recommended for this position, his acceptance would require a change of his role within the AIDS Office concerning auditing community based organizations.

The Mayor's Office will be informed of the decision of the Planning Council concerning the co-chairs, and which constituents and areas of expertise they should represent. Estela Garcia noted that the Planning Council needs to take this opportunity to have its own process to consider the positions of co-chairs. She wants the Council's process to parallel the DPH process. Accordingly, a process will be developed to make recommendations for co-chairs and for the reconfiguration of roles and responsibilities which would amplify the abilities of the Council. Continued discussion of this topic will be calendared for the meeting of September 20, 1993. Special outreach should be made to have all Council members present at this meeting. Individual members interested in becoming co-chairs should submit their names to Sophia Chang for consideration for presentation at the September 20, 1993 meeting.

Michael Shriver raised the issue of EMA representation on the Planning Council, specifically from San Mateo and Marin Counties.

The following motion was made:

> That the San Francisco Planning Council have representation from San Mateo and Marin Counties as voting members, and that they not be from the AIDS Office or the AIDS Commission Chair.

Sandra Hernandez explained that, historically, each of these counties has had its own HIV Planning Council, and that the San Francisco Planning Council has been a pass-through for funding. Sophia Chang clarified that, although not mandated to do so, an Inter-Governmental Agreement (IGA) with these counties has been developed and an IGA Subcommittee meets regularly which discusses regional issues and relationships with the State.

Michael Shriver argued that, because of regional accountability, it is desirable to have such representation on the Council.

Gene Copello, Director of the AIDS Program in San Mateo County, stated that he believed that the existence of the IGA Subcommittee has not always been known. At the very least, he would like to see more communication between the IGA Subcommittee and the San Francisco Planning

Council..He stated his disagreement with the previous motion that these county representatives could not be from the AIDS Offices of these counties. He stated that the person designated should be at the discretion of the local Board or Commission. However, he said that accountability could be addressed in other ways than representation on the San Francisco Planning Council.

Mr. Geoffrey Sackett, representing the Marin AIDS Commission, stated that whether or not as a voting member, they would like to be represented on the San Francisco Planning Council. There are many issues being addressed in Marin that have regional implications. It is currently developing a formal relatonship with Sonoma County and would like to develop one with San Francisco as well.

It was recommended that the motion be tabled until the next IGA meeting takes place on September 8, 1993. Gene Copello, from San Mateo, strongly supported this action, so that the Commissions in each County could consider whether on not they want such representation. Mr. Sackett from Marin, objected to the delay, stating that his Commission had already acted and already formally designated him to be the Marin County representative on San Francisco's Planning Council.

The following motion was made. This motion was passed with Barbara Garcia and Mary Jane Wood abstaining.

:

> To table the earlier motion that the San Francisco Planning Council have representation from San Mateo and Marin Counties as voting members, and that they not be from the AIDS Office or the AIDS Commisions in each county be fomally notified in writing to request input.

The following motion was made, and passed without opposition or abstention:

> To enable flexibility for attendance at Council meetings by amending Article 6 of the By-Laws, adding medical conditions as a reason to miss a meeting.

Language to amend the By-Laws will be drafted and brought back to the Planning Council for review. Dr. Chang noted that the entire By-Laws need to be updated. Planning Council members should review the By-Laws and discuss their revision at an upcoming meeting.

VIII. Update on Needs Assessments

Sophia Chang announced that she is in the process of cleaning the data set on the client based needs assessment. A total of 2,000 surveys are being evaluated. Bill Haskell announced that he is working with the San Francisco Redevelopment Agency on the housing needs assessment. Between 250 and 300 surveys are being evaluated. Sophia Chang announced that the long-range planning for system-wide services is well underway with the Support Center.

F
22
1
13-93

DOCUMENTS DEPT.
SEP 10 1993
SAN FRANCISCO
PUBLIC LIBRARY

SF

HIV HEALTH SERVICES PLANNING COUNCIL
September 13, 1993
25 Van Ness, Third Floor Conference Room
4:30 to 7:30 p.m.

Agenda.

I. Roll Call

II. Review of Minutes and Agenda

III. General Announcements

IV. Hearing Society Presentation
(Karen Rachels)

V. Report from Evaluation Subcommittee re: HOT

VI. Review and Approval of the Strategic Monitoring Process

VII. Review and Update of By-Laws

VIII. Update on Planning Processes--Long-Range and Housing

IX. Review of Future Meetings

09133aao

HIV HEALTH SERVICES PLANNING COUNCIL

September 13, 1993

The Minutes of this meeting are missing.

San Francisco Public Library
Government Information Center

HIV HEALTH SERVICES PLANNING COUNCIL

September 20, 1993

25 Van Ness Ave., Third Floor Conference Room

4:30 to 7:30 p.m.

AGENDA:

DOCUMENTS DEPT.
SEP 17 1993
SAN FRANCISCO
PUBLIC LIBRARY

I. Roll Call

II. Review of September 13th Meeting Minutes and Agenda

III. General Announcements
--Planning Council Review of CARE RFP Package

IV. Approval of Direct Program Funding in lieu of Subcontract
(Bay Positives)

V. Presentation of Draft Housing Needs Assessment Findings **(5 p.m.)**
--San Francisco Redevelopment Agency

VI. Discussion of EMA County Representation **(6 p.m.)**

VII. Discussion of the Role of Co-Chairs and Community Process for Co-Chair Recommendation

VIII. Presentation of Provider Perceived Needs

IX. Public Comment

93

Minutes.

DOCUMENTS DEPT.
OCT 01 1993
SAN FRANCISCO
PUBLIC LIBRARY

HIV HEALTH SERVICES PLANNING COUNCIL
September 20, 1993
25 Van Ness Avenue, Third Floor
4:30 - 6:20 p.m.

MEMBERS

Present: Pat Christen, Marcy A. Fraser, Yvonne Frazier, Barbara Garcia, Lester D. Hanson, Susan Karp, Gerald Lenoir, Gifford S. Leoung, James Loyce, Jr., Kent Macdonald, Scott Miller, J.B. Molaghan, Bob Nelson, Steve Roger, Laura Thomas, Rita Times, Jerry Windley, Mary Jane Wood.

Absent: Estela Garcia, Jaime Geaga, Steve Lew, Elliot S. Ramos, Mike Shriver, Reggie Williams.

Staff Present: Joseph Cecere, Valerie Dorr, Teri Dowling, Bill Haskell, Charles Brand.

I. Roll Call
Roll call was taken as above.

II. Review of Minutes and Agenda
The minutes of September 13 were reviewed. The following corrections were made: (1) Kent Macdonald did *not* abstain in the vote for approval of the August 30 minutes [Item II]; (2) Kent Macdonald abstained from the motion to accept the Subcommittee report to place the Health Outreach Team on probation; Lester Hanson *did not* abstain [Item V]; (3) "Item VIII. Other Items" should read "Item VIII*a*. Other Items"; (4) The Planning Council Public Hearing will be held September 27, *not* August 27 (Item VIIIa); Jenny Burroughs, RN of the CARE AIDS Clinic, *not* Jenny "Gross," addressed the Council (Item VIIIa). The minutes, as revised, were approved, with Rita Times and Steve Roger abstaining. The agenda of September 20, 1993, was approved.

III. General Announcements
•Earlier today Mike Shriver briefed Jerry Windley on the federal CARE budget markup. The situation is very promising. [See Attachment 1 for the 1994 funding summary of CARE funds, HOPWA (also known as AHOA) and the CDC-Prevention program.] Mike Shriver encourages everyone to write and thank Dianne Feinstein, Nancy Pelosi, Tom Harkins, Patty Murray and Connie Mack, who were instrumental in obtaining this markup.

•Bill Haskell recommended that the Council appoint a subcommittee to review the CARE RFP package before it is sent out in October. Kent Macdonald and Steve

Roger agreed to meet with Judith Weld and review the RFP during the week of October 4.

•Bill Haskell asked Council members affiliated with service provider organizations to consider participating in the "Service Providers" focus group, to be conducted by the Support Center on September 30, at 6:00 p.m.. Background information was distributed (Attachment 2). Lester Hanson agreed to participate.

IV. Approval of Direct Program Funding in Lieu of Subcontract (Bay Positives)

Valerie Dorr reviewed the background of this project. Bay Positives was formerly not a 501(c)(3) corporation. It provided peer facilitators by means of personal services contract to the Special Programs for Youth. This awkward process delayed services and some grant funds could not be used. Bay Positives has now become a 501(c)(3) corporation, thus eligible to receive grant funds directly. If the Planning Council approves augmentation of the existing contract, the $10,000 in question can be allocated directly to Bay Positives.

Scott Miller observed that the proposal, if approved, would not place the agency out of compliance with the Council's 70/30% rule.

J. B. Molaghan made the following motion, which was seconded:

> **To approve the transfer of $10,000 for peer facilitators, from Special Programs for Youth to Bay Positives.**

The motion passed with 14 in favor, none opposed, and 2 abstentions (Pat Christen, Scott Miller).

V. Presentation of Draft Housing Needs Assessment Findings -- San Francisco Redevelopment Agency

Deborah Drickersen Cortez and John Bouffard presented the HIV/AIDS housing needs assessment. Mr. Bouffard distributed the draft of his *HIV/AIDS Housing Needs Assessment: Consumer Preferences and Housing Resources in San Francisco* (September 1993). Council members were asked to review the draft report and submit comments to the Redevelopment Agency on the form that is attached to these minutes (Attachment 3).

Ms. Drickersen Cortez said that the needs assessment is informed by four pieces: (1) an extensive consumer survey; (2) a program staff survey that went out to a number of housing service providers; (3) information gathered from the community housing meetings sponsored by the AIDS Office during June, July and August; and (4) study of available documents and data. Housing need was difficult to portray quantitatively, due to lack of pertinent data. Although much

valuable information was obtained, the findings should be regarded as *qualitative.* The final document will include more information.

Mr. Bouffard observed that the primary focus of the report was on *needs and access.* Although the assessment was limited, non-random, and qualitative, it did target low-income persons with HIV/AIDS, the group clearly with the greatest need for appropriate housing. The survey questionnaire was distributed to 40 agencies who agreed to distribute them to their clients. Several other agencies providing services to the target group also volunteered to distribute the questionnaires. These included Health Outreach Team, Lyon-Martin Clinic, SFGH Ward 86, and Tom Waddell Clinic. Of 600 surveys sent out, 350 were returned. Some were late or disqualified for other reasons, leaving a sample of 282 responses.

Mr. Bouffard reviewed some cultural and social data about the respondents. Whites constituted 47%, African-Americans 23%, Asian/Pacific Islanders 8%, Latino/Latina 15%, and Native Americans 4%. Substance abuse issues were stated by 52%, and substance abuse plus mental health issues by 23.4%. A total of 8.5% of respondents had been recently incarcerated.

Q.- How much input did young people have?
A.- The youngest respondent was 21. We can break down the figures to explain how many young people responded, but that information is not available now.

Q.- What is the basis for the statement that "9% of persons who are homeless are living with HIV disease" (Page 14)? I have heard figures as high as 25%.
A.- We had three months to prepare the draft. The statistical part alone could have easily taken that long. We used the Zalopa-Moss figure of the San Francisco General Homeless Study Project. We felt that it was reflective of the homeless population with HIV.

Bob Nelson, who worked with the Redevelopment Agency on the project, observed that John Bouffard obtained ten times more data than anyone anticipated. Some of the data was surprising, especially regarding the location and types of housing the respondents preferred.

The Council responded with an ovation for Mr. Bouffard's work. Bill Haskell told the Council that the entire process, including the design of survey tools, the administration of the survey, evaluation of the data, and writing the report, occurred within three months: June through August.

J. B. Molaghan made the following motion, which was seconded and approved without opposition or abstention:

To commend John Bouffard and Deborah Drickersen Cortez for their excellent work in developing the HIV/AIDS Housing Needs Assessment and producing the draft report.

VI. Discussion of EMA County Representation

The Council discussed Marin County and San Mateo County representation on the Planning Council. Geoffrey W. Sackett, Co-Chair of the Marin AIDS Advisory Commission, and Gene Copello, Director of the AIDS Program in San Mateo County, participated. Members received a copy of the recommendation made by the Intergovernmental Affairs (IGA) Committee to: (1) approve such representation, with the qualification that their representatives not vote on motions regarding San Francisco funding priorities and allocation decisions concerning CARE and HOPWA funding, or when the Council sits as the San Francisco CARE Consortium (Title II); and (2) continue the IGA Committee as a committee of the San Francisco HIV Health Services Planning Council. (See Attachment 4.)

The following motion was made and seconded:

To adopt the recommendations of the IGA Committee regarding Marin County and San Mateo County voting representation on the Planning Council and the continuation of the IGA Committee.

The motion passed with 15 in favor, none opposed, and 1 abstention (Mary Jane Wood).

Q.- After the counties nominate a member to the Council, what will the process be?
A.- The Council will forward the names to the Mayor, who will appoint them formally.

The Council discussed the make-up of its membership. Were there too many members with agency and government affiliations, and too few consumers? Laura Thomas observed that the Council should not expect other counties to correct this deficiency. Mary Jane Wood suggested that such concerns be addressed to the subcommittee that was working toward the Council's goals regarding representation.

VII. Discussion of the Role of Co-Chairs and Community Process for Co-Chair Recommendation

Steve Lew and Mike Shriver generated this item, but who were absent. Rita Times suggested that the Council obtain their views in writing.

Members continued the August 30 discussion of the co-chair position and the motion that it include representation from the Department of Public Health and the community, one of whom must be HIV-positive. Barbara Garcia pointed out that if the male co-chair were HIV-negative, there might not be an HIV-positive female member willing to assume the second position. Mary Jane Wood suggested that the Council consider the possibility of *three* co-chairs, not only to increase the selection pool but also to ensure the presence of a chairperson at all meetings and improve coordination of responsibilities.

Laura Thomas listed important considerations in addition to gender parity and HIV status. Strong skills were required, particularly effectiveness in conducting meetings, and ability to serve as the public voice for the Council. Ideally, the latter should be an HIV-positive person. Pat Christen added that at least one co-chairperson should be able to represent the Council effectively before HRSA and other agencies, as well as at various meetings. Gender parity and HIV status were significant, but must be regarded within the context of these other important considerations. Gerald Lenoir pointed out another significant role: to effectively organize the Council's agendas. The Council has an excellent tract record in the quantity and quality of business conducted, but this had been due largely to the support of AIDS Office staff.

Scott Miller suggested that one co-chair position might be rotating. J.B. Molaghan suggested that the co-chairs should delegate alternates prior to each meeting. Jerry Windley observed that we cannot expect to always meet our ideals. Without a realistic description of the role, we might find ourselves coercing persons into a position that they either do not wish, or for which they do not feel prepared.

Yvonne Frazier was uncomfortable with the insistence that one co-chairperson be publically HIV-positive. While members might readily disclose their status to the mature and empathetic community of Council members, it still remained a highly personal matter to be public about one's HIV status. Persons interested in and qualified for appointment might refuse this position if it meant public disclosure of their status.

Barbara Garcia warned that a narrow range of skills would eliminate some qualified members. Pat Christen agreed that there is a skill-building consideration.

The following motion was made and seconded:

Pat Christen will prepare a draft statement of the primary roles and responsibilities of the co-chairs. It, to be discussed at the October 4 meeting.

The motion passed without opposition or abstention. (See Attachment 5.)

VIII. Presentation of Provider Perceived Needs

Bill Haskell distributed a list of needs and gaps in HIV services that providers identified in their 1992-1993 quarterly program reports (see Attachment 6). Teri Dowling prepared the list and will develop a spreadsheet that will indicate which providers identified each service gap, and whether such gaps actually exist. Bill said that the list was reviewed and augmented in a focus group of providers at the September 17 Health Services Advisory Committee meeting. Many providers were surprised and pleased that the AIDS Office utilized this information. It was also evident at that meeting that some providers had identified gaps because they were unaware that the service was actually being provided.

IX. Public Comment

There was no public comment.

ATTACHMENTS:

(1) AIDS Action Council, *Action Alert*, 9/16/93.

(2) Richard Fowler to Charles Brand/AIDS Office (fax 9/20);
- "New HIV Study will help revise Care System" (*San Francisco Sentinel*, 8/4/93;
- Support Center, "Are you an HIV/AIDS Service Provider..." (n.d.).

(3) Critique form re *HIV/AIDS Housing Needs Assessment* (draft).

(4) Recommendation of the Intergovernmental Affairs (IGA) Committee, 9/8/93;
- Geoffrey W. Sackett to Dr. Sophia Chang, 9/8/93;
- Noel Leca to Dr. Sophia Chang, 9/7/93.

(5 Pat Christen, "Roles & Responsibilities of Co-Chairs", 9/21/93.

(6) "Provider Perceived Gaps/Needs in HIV Services."

NEXT PLANNING COUNCIL MEETING:
PUBLIC HEARING
Monday -- September 27, 1993; 4:00-7:00 p.m.*
Glide Memorial United Methodist Church

(*Council members should be prepared to remain until 8:00 p.m. if necessary.)

San Francisco
Redevelopment Agency

770 Golden Gate Avenue
San Francisco, CA 94102

415.749.2400

FRANK M. JORDAN, Mayor

Cynthia Choy Ong, Acting President
Leroy King
Gary R. Kitahata
Jon Henry Kouba
Leslie T. Schilling
Clarence R. Stern

Edward Helfeld, Executive Director

The San Francisco Redevelopment Agency has distributed a draft of the HIV/AIDS Housing Needs Assessment to the HIV Planning Council for review and comment. Members of the HIV Housing Network and interested parties have also been invited to review the draft and offer comments and suggestions. In order to facilitate the incorporation of any comments or recommended changes received, the Agency is requesting that persons reviewing the draft Needs Assessment make their comments on this form. Please ***write clearly***, ***specify the section***, ***suggest alternate language***, and ***return this form by October 15, 1993*** to:

San Francisco Redevelopment Agency
770 Golden Gate Avenue
San Francisco, CA 94102

Attn: Deborah Drickersen Cortez

Name:_____ Telephone No. _____

---

i. Executive Summary

ii Acknowledgements

iii Introduction

A: Project background

B: Project Overview

C: How this report is organized

I. HIV Housing in San Francisco
A: Current HIV Housing System

B: Developing A Continuum of Housing

II. Analysis of HIV Housing Need and Supply
A. Housing Need
Summary of Overall Need

Summary of Special Populations Need

Detailed Description of Special Needs Groups

B. Housing Supply
Summary of Overall Supply

Detailed Description of Housing Programs

III. Analysis of Consumer Needs and Preferences

A. Consumer Survey Overview

B. Supportive Services
Needs of General Population

C. Housing Preferences of General Population
Facility Types, Neighborhoods, Housing Characteristics

D. Housing Preferences of Underserved and Special Needs Groups
Facility Types, Neighborhoods, Housing Characteristics

IV. Next Step
A. Next Step: Developing a Housing Plan

V. Appendices
A. Consumer Survey

September 17, 1993

PROVIDER PERCEIVED GAPS/NEEDS IN HIV SERVICES

The following list of needs and gaps in HIV services was identified by service providers in all 1992-93 quarterly program reports and by the AIDS Office program managers responsible for these services. Needs/gaps are arranged by Service Area category but may actually cut across other categories. Housing needs and gaps are not addressed in this listing. In addition, the Health Services Advisory Committee meeting held on September 17, 1993 was used as a focus group of service providers to assess existing gaps in HIV services. During this focus group, service providers, along with AIDS Office staff, identified additional gaps/needs, issues and concerns - noted on this list by a [o].

In attendance at this focus group were the following organizations: Walden House, St Mary's Hospital, UCSF AIDS Health Project, American College TCM, University of the Pacific - School of Dentistry, The Salvation Army - Harbor Light Center, San Francisco AIDS Foundation, Asian/Pacific AIDS Coalition, Westside Community Mental Health Services, Bridge for Kids/UnPuente para Ninos, Iris Center, Project Open Hand.

PRIMARY MEDICAL CARE

- More psychiatric emergency services
- Mental health beds
- Dental care, especially inpatient oral surgery
- Culturally sensitive medical services
- Free and low cost health care services
- Primary care physicians in Bayview CCSF clinics
- Faster access to neuro-psychological /cognitive assessments
- Urgent care clinics
- Psychiatric medication monitoring/evaluation
- Advertisement/public awareness of health care services currently available for low income persons
- HIV prevention efforts which specifically target immigrants and refugees
- Ability for undocumented persons to obtain services without a photo-I.D.
- Clinical trials available to individuals who speak only Spanish
- Placing patients who lack power of attorney for health care

OTHER PRIMARY CARE

- In-home and supplemental attendant care (especially for "difficult" patient populations)
- Information about medication resources
- Easy and timely access to pharmaceuticals (incl. delivery for homebound persons)
- Culturally appropriate food programs and nutrition education for Asians
- More adult day health services
- Free and low cost alternative treatments and therapies
- Collaboration between alternative therapies and traditional medical services
- Literacy level sensitive materials re: alternative medicine
- Concern around the level of training/compentency of attendants
- Inability to provide total caloric need of P.O.H. clients (98% of survey respondents indicated that P.O.H. is the only food they receive)

CASE MANAGEMENT

- Accurate and easily accessible information about and referral to available resources
- Coordination and planning for transition between hospital and community services
- Bilingual and culturally sensitive educators, outreach workers, care managers
- More entitlements
- Financial management services and representative payee programs
- Financial assistance programs (emergency, subsidy)
- Outreach to women (especially HIV + who are not yet sick), Latinos
- Emergency clothing and food
- Health education that is literary level specific and culturally appropriate
- Probate conservatorship for indigent clients with HIV cognitive impairments
- More medical case management
- Nutrition counseling
- Written education and resource information in Tagalog
- Case management for persons accessing both Chinese and Western Medicine
- Educate clients/physicians about non-western medicine alternatives for treatment
- Improve communication between Chinese and western medicine practitioners
- Outreach to families
- Probate conservatorship needs of non-hospitalized clients
- Better education re: Durable Power of Attorney and other powers of attorney
- Temporary guardianship for families
- Clarify residency definition
- Regional demands for service (dental care, dementia care, psychiatric care)
- Transition of incarcerated persons with HIV back into the community

PSYCHOSOCIAL SUPPORT

- Therapists of color/bilingual therapists in the volunteer therapy program
- Available childcare services and parenting classes (esp. for substance abuse residential treatment)
- Support for children of HIV parents
- Translation services for transgender populations
- Psychosocial support for partners (esp. of substance abuse clients) and survivors
- Network support for out of town family members
- Emergency cash for visiting families and adaptive equipment
- Summer program for school age children
- Bilingual and culturally sensitive counseling
- Mental health programs re: transsexualism and transvestism
- Programs for Gay/Lesbian Latinos run by Gay/Lesbian Latinos
- Free and low cost psychotherapy (including long-term therapy)
- Collaborative efforts among agencies
- Mental health services for all in need (asymptomatic to symptomatic, youth - especially with gender identity issues)
- Psychotherapy for homebound persons
- Support groups for heterosexuals
- Low cost transportation and transportation that can accommodate wheel chairs
- Treatment beds for HIV mental ill persons
- Lack of resources and knowledge about the Native American population
- Outreach to women, Latino population
- Volunteers providing practical support
- Prevention education and HIV service to incarcerated women
- Mobile lab services for transient/indigent/severely disabled PWA
- In-home attendant care for person not independ but don't qualify for skilled care
- SSI advocacy at General Assistance
- Crisis nursery
- What families can do around placement of kids and when DSS steps in
- Sensitive counseling to transgender/transsexuals/transvestites
- Mental health services for transgenders

SUBSTANCE ABUSE TREATMENT

- Inpatient substance abuse beds
- Separate groups for Gay and Lesbian substance abuse patients
- Programs for multiple diagnosed clients
- Free/low cost psychotherapy and counseling for users
- Childcare for females in residential treatment
- Inpatient/outpatient programs for Latino substance abusers
- Methadone slots for HIV patients
- Substance abuse support groups
- Services to women on methadone maintenance
- Primary drug/alcohol treatment for HIV infected substance abusers
- Long-term and acute medical detox
- Residential substance abuse treatment programs for: Spanish speakers, Lesbians, adolescents under 18
- Support groupsfor families of substance abusers
- Long term "clean and sober" housing for persons who are HIV+
- Residentail methadone slots (detox or maintenance)
- In-patient /outpatient/residential treatment for Asian/Pacific Islanders

SYSTEM WIDE PROBLEMS

- Need for a coordinated, consumer friendly system to facilitate the movement of clients through the system from higher levels of treatment to independent living (need a comprehensive system of care)
- More city-wide planning to address mental health needs of the community - especially in light of new programs (Leland Avenue Residence, Westside Chateau, Hope House, etc.)
- Intrepreting services for the deaf
- Lack of African American providers in the Bay Area
- Information regarding availability of deaf interpretation services
- Resource guide for HIV services (not just CARE funded) for both providers and clients
- Recognition of the need to provide services for related persons who are HIV-

AIDS Action council

ActionAlert

For More Information Contact:
Karen Ringen, 202-986-1300 ext 16.

September 16, 1993

Dear Colleague:

Both the Senate and House appropriations committees that determine most of the federal AIDS funding have now met, and within the next month will have to work out the differences in their bills in conference committee. As you can see from the chart (on reverse), the Senate funding was $10 million more than the House for the Ryan White Care Act. (CDC Prevention money and NIH research dollars were the same.) The AIDS Housing Opportunities Act also fared better in the Senate, with a $31 million increase over the House.

Both bills still have to go to the Senate floor. ***Please call or write your Senators within the next ten days and ask them to vote for the Labor/HHS and VA/HUD appropriations bills without amendments.***

When the Labor/HHS bill goes to the floor, there are often attempts to attach negative HIV amendments (i.e. restrict federal funds for condoms, needle exchange programs, etc.) Please ask your Senators to vote against such attempts, and let them know that you would like to become a resource to Senate staff should negative amendments be offered.

Sample Letter

Senator _____
U.S. Senate
Washington, DC 20510

Dear Senator:

I am writing to ask that you support the increases in AIDS funding for the Department of Health and Human Services in the Labor/HHS appropriations bill and the increases for AIDS Housing in the VA/HUD appropriations bill when both bills come to the Senate floor. In addition, I request that you vote for both bills without amendments.

In past years there have been attempts to attach negative HIV legislation to the appropriations bills. We ask that you vote against such attempts and vote for the bill in its current form. Please feel free to contact my office *(provide your phone number)* if you have any HIV related questions.

Sincerely,

(If you would rather call, the Senate switchboard number is: 202-224-3121.)

1875
Connecticut Ave NW
Suite 700
Washington DC
20009
Fax 202 986 1345
Tel 202 986 1300

ATTACHMENT ONE

FEDERAL AIDS PROGRAMS FY 94 FUNDING SUMMARY

(Numbers are rounded to the nearest million.)

HIV/AIDS-SPECIFIC PROGRAMS	FY 93 FUNDING	FY 94 President's Budget Request *(increase over FY 93)*	FY 94 House Numbers *(increase over FY 93)*	FY 94 Senate Numbers *(increase over FY 93)*	FINAL FY 94 NUMBERS *(To be determined)*
NIH-Research	$1.073 billion	+ **$227 million**	+ $227 million	+ $227 million	
CDC-Prevention	$498 million	+ **$45 million**	+ $45 million	+ $45 million	
Ryan White CARE Act: totals	$348 million	+ **$310 million**	+ $203 million	+ $213 million	
Title I	*$185 million*	+ *$151 million*	+ $133 million	+ $143 million	
Title II	$115 million	+ *$119 million*	+ $69 million	+ $69 million	
Title IIIB	$48 million	+ *$34 million*	+ $0	+ $0	
Title IV	$0	+ *$6 million*	+ $22 million* ($1 million net)	+ $22 million*	
AIDS Housing Opportunities Act (AHOA)	$100 million	+ **$3 million**	+ $25 million	+ $56 million	

* $21 million from the Pediatric AIDS Demonstration Programs was transferred into Title IV, thus the real funding increase was only $1 million.

Support Center San Francisco

70 Tenth Street, Suite 201 • San Francisco, CA 94103-1302 • (415) 552-7584 • FAX (415) 552-8824

FAX COVER SHEET

DATE: 9/20/93

ATTN.: Charles Brand

OF: AIDS Office

FAX NO: 431-7547

FROM: Richard Fowler & Tim Wu

TOTAL NO. OF PAGES (including this page): 3

ADDITIONAL COMMENTS:

Thank you for informing the HIV Planning Council at today's meeting about our upcoming Service Provider focus groups.

Following are an S.F. Sentinel article describing the study, and a flyer for service providers, which may assist Planning Council members in the recruiting effort.

If you have any questions, please don't hesitate to call, at 552-7584.

Thank you again very much.

SEPT. 30, 6:30 PM

"AIDS Providers Focus Group"

S.F. Sentinel 8/4/93

New HIV Study Will Help Revise Care System

The AIDS Office of the San Francisco Department of Public Health, in conjunction with the HIV Health Services Planning Council, has announced the creation of a new project which will document the experiences of the city's HIV community.

This project is the first step of a long-range plan aimed at revising the current system of care in order to create a more client-oriented, client-focused system which will better meet the need of a community grappling with the changing nature of the epidemic.

The study, which will run through the end of the year, will use focus groups and interviews to document the experiences of individuals with HIV who are representative of San Francisco's varied multilingual, socioeconomic, and ethnically-diverse communities. The study will also conduct interviews with a variety of HIV service providers who assist individuals with HIV in navigating the health care and referral system. The primary goal of the study will be to determine, from personal experiences of those most directly affected, the successes and shortcomings of the current "San Francisco" model of service delivery, as it operates through a decentralized network of community-based nonprofit organizations. The data collected from this study will enable health care planners to develop a hierarchy of needs and characteristics for HIV services in San Francisco which more accurately reflects the priorities and experiences of those receiving care.

The Support Center for Non-Profit Management has been chosen by the AIDS Office to conduct the study, and to develop the methodology and scope of the project. For further information about the project, please call Richard Fowler, Project Coordinator, at the Support Center at (415) 552-7584, ex. 314. ■

Are you an HIV/AIDS Service Provider who works directly with clients?

We want to hear from you. . .

The Support Center is conducting two focus groups to hear your perspectives and observations of what your clients have experienced in seeking HIV services.

Focus Group #1: Service Providers
Thursday, 9/30/93, 6:00 pm

Focus Group #2: HIV+ Service Providers
(Service Providers who are HIV+ themselves)
Thursday, 9/30/93, 8:00 pm

Both groups will be held at The Support Center Annex:
1385 Mission Street, Suite 231
(Mission at Tenth St.)

To join a focus group, you must sign up by 9/28/93, by calling Richard Fowler at The Support Center: (415) 552-7584, ext. 314.

SAN FRANCISCO HIV SERVICES PLANNING COUNCIL

Intergovernmental Affairs (IGA) Committee

Members of the IGA committee, meeting on September 8, 1993, agreed on the following recommendations made to the Planning Council:

I. Marin County and San Mateo County, as parts of the San Francisco Ryan White CARE Act Title I EMA, will each have one voting seat on the San Francisco HIV Services Planning Council. These representatives will be selected by the respective planning bodies in each of the two Counties. The representatives will refrain from voting on motions regarding San Francisco funding priorities and allocation decisions in regard to the Ryan White CARE Act Title I and to HOPWA funding. In addition, the two representatives will refrain from voting on any and all issues when the Planning Council sits as the San Francisco CARE Consortium (Title II). The two Counties will continue to receive formula funding under the Ryan White CARE Act Title I and HOPWA based on the number of reported people living with AIDS. Each of the two Counties will continue to utilize local planning bodies in funding prioritization and in making local allocation decisions. In addition to the formula funds, each of the two Counties will be eligible to compete for supplemental funds under the Ryan White CARE Act Title I. On an annual basis, each of the two Counties will report to the Planning Council about HOPWA and Ryan White CARE Act Title I activities.

II. The IGA Committee will remain a San Francisco HIV Services Planning Council committee. Its programmatic, public policy, and planning activities will continue to focus on the IGA region, however, federal and state issues will continue to be addressed. The current committee membership consisting of each County AIDS Director will be expanded to include one community representative from each County selected by the respective local planning body. The Chair of the IGA Committee will continue to rotate among County AIDS Directors. On a periodic schedule, established by the San Francisco HIV Services Planning Council, the IGA Committee Chair will provide a committee report to the planning council.

COUNTY OF MARIN
Department of Health & Human Services
AIDS Advisory Commission

20 North San Pedro Road, Suite 2002
San Rafael, CA 94903
415/499-7804

September 8, 1993

Dr. Sophia Chang
Chief, Health Services Branch
San Francisco AIDS Office
25 Van Ness Avenue, Suite 500
San Francisco, Ca. 94102-6033

Re: Your letter of September 1, 1993

Dear Dr. Chang,

Thank you for the opportunity to explain the position of the Marin AIDS Advisory Commission regarding voting membership on the S.F. Planning Council. For some time our Commission has been the beneficiary of the S.F. Planning Council's decision to fund our efforts through a percentage distribution of Ryan White CARE Act Title I monies. As with San Mateo County, Marin County wishes to acknowledge that this has been of great help in our development and delivery of services to persons living with HIV/AIDS in Marin.

As you are well aware, Marin has had sporadic attendance at the S.F. Planning Council meetings, usually prodded by funding cycles to represent our interests. We wish to formally state that we feel we owe a commitment to participate on a regular basis in a more regional representative body and since we are part of the San Francisco EMA it is our hope to cement our relationship through a seat on the S.F. Planning Council.

As we discussed today, Marin feels that: 1.) the percentage distribution of Ryan White CARE Act Title I should be maintatined, 2.) the Marin AIDS Advisory Commission should decide its funding and allocation decisions within the geographical boundaries of our county, 3.) Marin should have <u>no involvement</u> in any decision making process with regards to distribution of Ryan White CARE Act Title I funds within the geopgraphical boundaries of either San Francisco or San Mateo Counties.

If I can be of any further assistance in explaining Marin's desire to work more closely on an ongoing basis with the S.F. Planning Council please feel free to contact me.

Sincerely yours,

Geoffrey W. Sackett, Co-Chair
Marin AIDS Advisory Commission

cc: Jon Dean Green, Director
Marin County AIDS Program
Tom Fairwell, Co-Chair
Marin AIDS Advisory Commission

SEP 10 1993

alth Services Agency
DS PROGRAM

BOARD OF SUPERVISORS
RUBEN BARRALES
MARY GRIFFIN
TOM HUENING
TED LEMPERT
MICHAEL D. NEVIN

COUNTY OF SAN MATEO

MARGARET TAYLOR
DIRECTOR OF HEALTH SERVICES

3700 EDISON STREET • SAN MATEO • CALIFORNIA 94403 TELEPHONE (415) 573-2588

Dr. Sophia Chang
Chief, Health Services Branch
San Francisco AIDS Office
25 Van Ness Avenue, Suite 500
San Francisco, CA 94102-6033

September 7, 1993

Dear Dr. Chang:

Thank you for your letter received September 3. I want to acknowledge the positive relationship between San Mateo County and the City and County of San Francisco in regard to coordination of the Ryan White CARE Act Title I. The formula funding based on the number of people living with HIV received by San Mateo County from the San Francisco HIV Health Services Planning Council has been instrumental to the development of comprehensive health and social services in San Mateo County.

The San Mateo County AIDS Program Community Advisory Board is a 30 member community-based board which serves advisory and allocation functions for HIV prevention, treatment, and care services in San Mateo County. Included among these functions, the board is the planning council for Ryan White CARE Act Title I funding. A specific planning process is used for all HIV funding. This process includes an ongoing client survey as well as client participation on the board. Extensive information about our planning process and current programs was provided to you during your site visit in December 1992. The summary protocol for the planning process is enclosed. I have also enclosed the 1992-1993 HIV annual report prepared by the San Mateo County AIDS Program. The report details the delivery of health and social services to over 700 clients and prevention services to over 30,000 individuals during 1992-1993. Dr. Gene Copello, AIDS Program Director for San Mateo County, can provide you with additional copies of the annual report if necessary.

You asked in your letter for an opinion regarding voting representation on the San Francisco HIV Health Services Planning Council from San Mateo County. Generally, Dr. Copello has represented San Mateo County at your meetings and through the regional work of the Intergovernmental Affairs (IGA) Committee. While this representation has been ex-officio, San Mateo County has not experienced any difficulties in regard to the San Francisco planning council nor the San Francisco AIDS Office. Voting

representation would amplify the presence of San Mateo County and would bring a metropolitan perspective to the San Francisco planning council. I have some concerns about such representation:

1. It needs to be clarified that one voting representative cannot reflect San Mateo County's diversity on a San Francisco council;

2. The current arrangement whereby a formula funding percentage based on the number of persons living with HIV is granted to San Mateo County needs to be preserved;

3. San Mateo County, through its local planning process, needs to continue to decide its own funding priorities and to continue to make its own allocation decisions in regard to Ryan White CARE Act Title I funds;

4. San Mateo County has found the IGA Committee to be an important network for regional, state, and federal issues and this committee needs to continue its work on these issues.

The San Mateo County AIDS Program Community Advisory Board would welcome voting representation on the San Francisco planning council provided these four concerns were addressed. I have no reason to believe this will not be the case and will move forward on this concept. Our board does not meet in full session again until September 23. At that meeting I will ask the membership to ratify this concept and nominate a representative. Following this meeting I will forward to you the name of our nominee so you can make the necessary arrangements with Mayor Jordon's office.

I want to thank you for this opportunity on behalf of our board and the clients living with HIV in San Mateo County. This action will serve to further strengthen the excellent working relationship between our two planning bodies and between your office and the San Mateo County AIDS Program.

Sincerely,

Noël Leca
Chair
San Mateo County AIDS Program Community Advisory Board

cc: Dr. A. Gene Copello, Director

SAN MATEO COUNTY AIDS PROGRAM
1994-1995 STRATEGIC PLANNING PROCESS

PHASE I: COLLECT INFORMATION (Completed by March 1994)

Client Input: Focus Groups and Surveys
AIDS Program Staff Input: Area, Section, and Program-Wide Staff Meetings
Input from AIDS Program Contract Agencies
Advisory Board Committee Needs Assessments and Reports
Review of Epidemiological Data
Review of AIDS Program and Contract Agency Service Data
Review Requirements of Funding Agencies

PHASE II: DEVELOP PROGRAM PLAN AND BUDGET (Completed by March 1994)

County Process (Goals, Budget, Budget Narrative)
AIDS Program-Wide, Area, and Section Goals
Development of Objectives
Development of Evaluation Plan
Review Revenue Picture

PHASE III: FINAL PLANNING AND PRESENTATION (Completed by April 1994)

AIDS Program Management Committee
Health Services Agency Administration
Advisory Board Executive Committee
AIDS Program Director Presents 1993-1994 Plan and Budget
Plan and Budget Endorsement at Advisory Board Annual Meeting

PHASE IV: COMPLETION OF THE APPROVAL PROCESS (Completed by July 1994)

Letters of Transmittal Regarding Advisory Board Endorsement
County Manager's Office
Adoption of Recommended Budget by Board of Supervisors
Adoption of Final Budget by Board of Supervisors

PHASE V: ONGOING EVALUATION (Ongoing/Completed by July 1995)

Periodic Staff Review of Goals and Objectives
AIDS Program Management Committee Review
Adjustments to Plan and Budget as Needed
Monitorings by Advisory Board Committees as Needed
AIDS Program Director's Reports to Advisory Board Executive Committee
AIDS Program Director's Advisory Board Quarterly Reports
Annual Report

MEMORANDUM

Date: 21 September 1993

To: HIV Services Planning Council

From: Pat Christen

Re: Roles & Responsibilities of Co-Chairs

Per our discussion at the Planning Council meeting last evening, I agreed to draft a list of the major roles and responsibilities of the Co-Chairs of the Council.

Please note that this is a first draft and that I was trying to capture major areas of concern, though I may well have forgotten some rather significant ones.

It is my understanding that we will discuss this at the first Council meeting in October.

Thanks.

HIV Health Services Planning Council
Co-Chair Roles & Responsibilities

1) Coordinate AIDS office support staff activities relating to the Council's work.

2) Chair Planning Council meetings according to basic principles of Robert's Rules of Order.

3) Ensure provision of public testimony at Council meetings is carried out in a sensitive and timely fashion.

4) Serve as spokesperson for Council to print media.*

5) Serve as spokesperson for Council to electronic media.*

6) Represent Planning Council concerns/priorities in meetings with HRSA, State Office of AIDS and Mayor's office.

7) Provide testimony in Federal and State arenas in coordination with CAEAR Coalition activities.

* These two areas - print media vs. electronic media - have been delineated separately as they require different skills that may or may not be found in the same person.

Table 1. Estimated HIV Populations by Ethnicity, Gender and Age in San Francisco as of June 30, 1993

POPULATION	WHITE			BLACK/AFRICAN-AMERICAN		
	Male	Female	Pediatric	Male	Female	Pediatric
# Alive w/ AIDS	4,454	88	5	618	81	7
# w/ CD4 < 200	3,507	32	12	371	27	6
# w/CD4 > =200	8,387	414	12	2,930	321	16
Subtotals	16,348	534	29	3,919	429	29
TOTAL	16,911			4,377		

POPULATION	HISPANIC/LATINO			ASIAN/PACIFIC ISLANDER		
	Male	Female	Pediatric	Male	Female	Pediatric
# Alive w/ AIDS	576	33	0	128	13	0
# w/ CD4 < 200	474	12	4	132	4	1
# w/CD4 > =200	2,675	71	12	1,968	35	7
Subtotals	3,725	116	16	2,228	52	8
TOTAL	3,857			2,288		

POPULATION	NATIVE AMERICAN			OTHER		
	Male	Female	Pediatric	Male	Female	Pediatric
# Alive w/ AIDS	21	4	0	N/A	N/A	N/A
# w/ CD4 < 200	57	0	0	N/A	N/A	N/A
# w/CD4 > =200	103	3	1	N/A	N/A	N/A
Subtotals	181	7	1	N/A	N/A	N/A
TOTAL	189			N/A		

POPULATION	TOTALS: ALL POPULATIONS		
	Male	Female	Pediatric
# Alive w/ AIDS	5,797	219	12
# w/ CD4 < 200	4,541	75	23
# w/CD4 > =200	16,063	844	48
Subtotals	26,401	1,138	83
GRAND TOTAL	27,622		

DRAFT

Table 2. Estimated HIV+ Population by Transmission/Risk Category in San Francisco as of June 30, 1993

2.a. Estimated ADULT HIV+ Population	Male	Female	Total
Men who have sex with men			
# Alive with AIDS	4,903		4,903
Est. # with <200 CD4 cells/mm3	4,133		4,133
Est. # with >=200 CD4 cells/mm3	14,122		14,122
Est. Total HIV+ this Risk/Transmission Category	23,158		23,158
Injecting drug use			
# Alive with AIDS	354	134	488
Est. # with <200 CD4 cells/mm3	82	30	112
Est. # with >=200 CD4 cells/mm3	750	337	1,087
Est. Total HIV+ this Risk/Transmission Category	1,186	501	1,687
Men who have sex with men and inject drugs			
# Alive with AIDS	439		439
Est. # with <200 CD4 cells/mm3	256		256
Est. # with >=200 CD4 cells/mm3	1,125		1,125
Est. Total HIV+ this Risk/Transmission Category	1,820		1,820
Hemophilia/coagulation disorder			
# Alive with AIDS	12	0	12
Est. # with <200 CD4 cells/mm3	16	0	16
Est. # with >=200 CD4 cells/mm3	0	0	0
Est. Total HIV+ this Risk/Transmission Category	28	0	28
Heterosexual contact			
# Alive with AIDS	12	57	69
Est. # with <200 CD4 cells/mm3	16	18	34
Est. # with >=200 CD4 cells/mm3	0	352	352
Est. Total HIV+ this Risk/Transmission Category	28	427	455
Transfusion/other blood component or tissue			
# Alive with AIDS	23	19	42
Est. # with <200 CD4 cells/mm3	31	6	37
Est. # with >=200 CD4 cells/mm3	0	117	117
Est. Total HIV+ this Risk/Transmission Category	54	142	196
Undetermined			
# Alive with AIDS	54	9	63
Est. # with <200 CD4 cells/mm3	7	21	28
Est. # with >=200 CD4 cells/mm3	66	38	104
Est. Total HIV+ this Risk/Transmission Category	127	68	195

DRAFT

F
22
1
-27-93

SF HIV Health Service Planning Council

DOCUMENTS DEPT.
SEP 10 1993
SAN FRANCISCO
PUBLIC LIBRARY

NOTICE OF PUBLIC HEARING ON HIV SERVICE NEEDS

Monday, September 27, 1993
4 to 7 p.m.

Glide Memorial United Methodist Church
330 Ellis Street, San Francisco

Consumers of HIV services are encouraged to testify before the Mayor's HIV Health Services Planning Council regarding gaps in service and the best means for filling them. Presentations are limited to three (3) minutes. Sign language interpretation will be available.

The Council is responsible for the allocation and use of local Ryan White Comprehensive AIDS Resources Emergency (CARE) funds in San Francisco.

Written testimony may also be submitted. Forms are available from the AIDS Office, 25 Van Ness, 5th Floor. Forms must be returned by October 4, 1993.

For further information, call 554-9549.

ATTACHMENT TWO

HIV Health Services Planning Council

PUBLIC HEARING

September 27, 1993

On September 27, 1993, a public hearing was held at Glide Memorial United Methodist Church, for the purpose of obtaining testimony from persons about perceived service gaps in HIV services in San Francisco. The meeting was widely advertised, and signing and translation services were available. A quorum of Planning Council members was present, as well as James Loyce, Jr., Sophia Chang, Valerie Dorr, Bill Haskell, and Charles Brand of the AIDS Office staff. Gerald Lenoir and Steve Lew presided. Fifteen persons testified.

1. [redacted] White male. HIV+.
MAJOR FOCUS: Housing.
Trying for three years to procure affordable housing, to save more SSI and disability income to live on. Housing Authority obstructive. Westside informs him public housing would be unsuitable, anyway. Still renting flat, which consumes most of his income.

2. **Alfredo Armendariz.** Latino male. Provider *(PLUS Program)*.
MAJOR FOCUS: Psychosocial.
Workshop leader. Seeking CARE funds.

3. **Rob Tufel.** White male. Provider *(Special Services Program)*.
MAJOR FOCUS: Psychosocial, Housing.
★Uninfected relatives generally neglected. ★Families, especially children, need counseling and emotional support. Little followup after death, of patient's children or grandparents who often become responsible for their care. ★Housing needs of HIV+ persons, and attendant respite care needs, are ignored. Children's Protective Service has some services, but inappropriate and often unacceptable to HIV+ parent. The best solutions for children of hospitalized patients, isto bring someone into the home (if the parents agree), or, more feasibly, to pay relatives to provide such care.★Housing needs of survivors unmet. ★★The main service gap is adequate services for asymptomatic persons. Most agencies will not get involved.

80% of HIV+ females have children, usually 2 or more. The program always has 7–9 families enrolled, with a total of approximately 16 kids. Some families are homeless. Others often have dangerous or inadequate arrangements. Most clients want Section 8 (subsidized) housing. Clients are multilingual and multiethnic, and the only criterion is AFDC participation. In their experience, finding competent staff is a greater challenge than funding.

4. **Jennifer Liu.** Asian female. Provider *(American College TCM)*.
MAJOR FOCUS: Medical – Other.
★Chinese traditional medicine inadequately funded. They get some CARE funds, and now operate at 120% of units-of-service. The waiting list exceeds 120, and a one-year wait is usual. Those on waiting lists are offered movement classes. As the list grows, clients are restricted to a 12-week program; after which they are reassessed. The objective is to accommodate as

many as possible. The rise in demand is steady and progressive. Any HIV+ will be seen. The main need now is for more clinical space.

5. [redacted] White male. HIV+.
MAJOR FOCUS: Psychosocial; Housing, Medical-Other, Substance Abuse.
• ★Difficult to access mental health therapy programs. Waiting lists mean that therapy is often unavailable at time of greatest need. ★No post-recovery transition. ★Difficult to access housing and adjust to congregate living. Waited 18 months for Shanti housing; probably entered this quickly because his old place burned. Shanti residents are on the older side, which may bother younger persons in need. ★Insufficient emphasis on preventive education. ★Excessively long wait for Chinese traditional medicine. ★Outrageous 4-month wait for short-term therapy. ★Need agencies that provide services to persons under 26 years of age. Client of Bay Positives, which alone now serves this group. ★Some agencies insensitive. One insisted he prove his statements about rent and insurance premiums.

6. [redacted] White male. HIV+.
MAJOR FOCUS: Case Management, Housing, Psychosocial
Recently incarcerated. ★Prison system provides inadequate education, intervention and follow-up. Prisoners are misinformed, and lack the awareness to cooperate fully with physicians. ★Discharge planning and support services non-existent, except where recently begun by Volunteers of America for males released from San Quentin and Vacaville to Alameda and San Francisco counties. Released prisoners need case management, benefits counseling and housing.. •HIV persons do not willingly return to prison. Rather they are dumped without resources or support. Their desperate reaction results in a new conviction.

7. [redacted] Asian male. HIV+.
MAJOR FOCUS: Housing, Case Management
(His delivery was translated from Mandarin by Winny Han of CHP.) ★Difficult to obtain adequate housing and ★benefits counseling. After great anxiety, connected with GCHP and being helped. Still needs housing and disability coverage. Lives independently, but in a deplorable tenement situation.

8. [redacted] Asian male. HIV+.
MAJOR FOCUS: Case Management.
Difficult to handle ★financial pressures and responsibilities, even though still physically asymptomatic. ★Cannot deal with the message that relief will come only following AIDS diagnosis. Has used services of GCHP and Bay Positives.

9. **Randolph Miller.** African American male. Provider *(NTFAR)*
MAJOR FOCUS: Psychosocial; Case Management.
People-of-color agencies need assistance in responding to pressure for consolidation into larger, probably white-dominated groups. ★Urgent to stress cultural sensitivity as much as efficiency, especially in the light of new demographics. Hard to be creative when scrambling for deliverables. ★Need assistance in non-clinical operational matters. ★★Greatest gaps are housing, ★financial support and ★peer advocacy. ★Clothing and ★food support also need attention. .

10. **Sharon Esher, RN.** White female. Former provider (UCSF).
MAJOR FOCUS: Medical; Psychosocial.
Listed effects of recent 50% NIH funding cut on what had been a quality pediatric HIV care program. Although the funds were for basic research, they also covered some patient care. Most patients are uninsured and the University will not support them. Extensive donations are

usually dedicated to basic research. The three centers now receive $850,000, down from last year's $1.4 million. This figure must cover 300 patients in three centers. The census of HIV kids and indeterminate babies continues to rise. The cut forced loss of one RN position and .5 developmental psychologist and .3 social worker time. The clinic treated about 100 pediatric clients. (Rita Times: March 1993 Stanford statistics indicates that there are 480 pediatric cases in Northern California, including 128 in San Francisco. [Esher was advised that the Council cannot use CARE funds to replace decreases in funding; but that the CBO should stress gaps in services.]

11. **Juan J Oyarzin.** Latino male. Provider
MAJOR FOCUS: Substance Abuse.
The Mission comunity is concerned that there is ★no local residential treatment or ★culturally sensitive housing facility. ★If DPH/CARE only funds older agencies, his agency will discuss collaborative moves to address these gaps. They are working with the Drug Abuse Advisory Board and Polaris. The speaker is on that board and is a DSS Commissioner, and the community is becoming acquainted with Latino needs.

12. [redacted] White male. HIV+ (1986).
MAJOR FOCUS: Psychosocial; Housing
★Tenderloin people are ignored and ★housing is deplorable. Six years in Ambassador Hotel. This should not be a final housing remedy. Suffering from insect bites. Hyperallergenic, but often receives ★inappropriate medication. Fearful of neighborhood, where he has been mugged. No outreach to many HIV+ neighbors, who depend on him for any assistance with system. ★Lost contact with former social group of survivors. DPH squelched AIDS Indigent Services, one of the few effective groups in this area. This ended access to an RN, social worker, or visiting services. ★Agency social workers are abrupt and peremptory; and proprietary about where clients are referred.

13. [redacted] Asian male. HIV+ (1987).
MAJOR FOCUS: Psychosocial; Medical – Other.
Just began to need services. Indigent. ★Supports consolidation if this strengthens smaller, effective agencies. ★Must wait months for individual counseling, although real needs it now, with friends dying. One friend was in hospice 6 – 8 months but could not obtain counseling. Why postpone this until person develops AIDS? ★Families also need help. ★Need more facilities like Health Center One, ★more culturally sensitive services, and ★alternative medicine. Health Center One referred him to Operation Concern, where he was treated derisively and told that he must wait two months for 8 – 10 weeks of counseling.

14. [redacted] Native American male. HIV+.
MAJOR FOCUS: Housing; Case Management, Psychosocial.
Came from New York state, where he could not obtain appropriate services. HIV-disabled last year. Oakland Native American Health Center funding cut more than 30%, yet East Bay Native American HIV population grows twice as fast as others. ★No assistance to access services or ★cover rent increases. People were becoming homeless because of cutbacks. ★ Medi-Cal stopped covering his medication, but generic is not as effective, and he is hyperallergenic. Must pay $150/prescription. ★SFGH callousl, impersonal. 6 – 8 hours wait for treatment. ★Excessive focus on research, where physicians make big dollars. Need Basic, equitable services. ★Persons must change locations to access better treatment, and this surely inflates systemic costs. ★Providers are insensitive to HIV population. How many have HIV+ persons on their boards? Ask the infected for information. He would gladly campaign for CARE.

15. **Kenneth Akinaka.** Asian male. Provider.
MAJOR FOCUS: Substance Abuse.
Their grantwriter probably feels discouraged because of past rejections by San Francisco, where they are largest provider of substance abuse services, serving 1,000 outpatients each day. Each clinic has 500–600 clients. CARE-supported Richmond clinic has 250 clients. Up to 20% are HIV+. If reimbursed they could provide ★testing and ★primary care on an outpatient basis. They have adequate staffing and can proceed if they are funded at a minimal fee-for-service rate. ★Many clients will not go to SFGH, and will only access services we provide on site. ★ In the future, expect home service visits to become an urgent issue. [Speaker was advised to submit a proposal this year.]

16. **Alejandro Dorenbaum.** White male. Provider-affiliated (UCSF).
MAJOR FOCUS: Medical; Psychosocial.
[Also see **Sharon Esher** (#10) for Clinic.] Although their clinic is pediatric, ★many mothers are HIV+, and an extra nurse and social worker are necessary to gear them toward treatment. HIV+ mothers are generally reluctant to disclose their status. Many are indigent and cannot get psychosocial support. The clinic ★should be a mechanism to serve them. ★ Transportation is needed, since patients often miss clinical treatment because of transportation difficulties. The clinic could subcontract use of the Oncology Team's van. All of this could be implemented for approximately $350,000. UCSF is now the only licensed pediatric HIV primary care clinic in San Francisco, but SFGH 9is being developed to provide them.

o/wp/brand/pubhrg.doc

SERVICE GAPS IDENTIFIED BY SPEAKERS AT PUBLIC HEARING

SERVICE GAP	CLIENTS	Total CLIENTS	Percent of CLIENTS	PROVIDERS	Total PROVIDERS	Percent of PROVIDERS
Case Mgt.	6, 7, 8, 12 , 14	5	62.5%			
Housing	1, 5, 6, 7, 12	5	62.5%	3, 9, 11	3	37.5%
Cultural Sensitivity	7, 13, 14	3	37.5%	9, 11,	2	25%
Chinese Med.	5, 13	2	25%	4	1	12.5%
Benefits Counseling	6, 7,	2	25%			
Counseling	5, 13	2	25%	16	1	12.5%
General, for Asymptomatic	8, 13	2	25%	3	1	12.5%
Medical Care	12, 14	2	25%	10, 15, 16	3	37.5%
Medication	12, 14	2	25%			
Counseling, family	13	1	12.5%	3		
Counseling, group	12	1	12.5%	2,	1	12.5%
Education	6,	1	12.5%			
Followup	6,	1	12.5%			
General, for Youth	5	1	12.5%			
Home Medical Visit	12,	1	12.5%			
Outreach	12,	1	12.5%	16	1	12.5%
Childcare				3	1	12.5%
Clothing				9	1	12.5%
Financial Support				9,	1	12.5%
Food				9	1	12.5%
Peer Advocacy				9	1	12.5%
Respite care				3	1	12.5%
Treatment, Residential (SA)				11,	1	12.5%
Testing				15,	1	12.5%
Transportation				16	1	12.5%

ATTACHMENT THREE

October 1, 1993

OCT 4 '93

HIV Health Services Planning Council Members
c/o Dr. Sophia Chang
Chief, Health Services Branch
San Francisco AIDS Office
25 Van Ness Avenue, Suite 500
San Francisco, CA 94102-6033

Dear Planning Council Members:

This is just a reminder that as you look to inform the process for prioritizing CARE services, that you not forget the document that was developed last year titled, "People of Color and HIV/AIDS: Planning for Treatment and Services in San Francisco".

The document had the strong support of A/PAC, the American Indian AIDS Institute, the Black Coalition on AIDS and the Latino Coalition on AIDS/SIDA. Included are quite an extensive list of service gaps in providing HIV services to communities of color in San Francisco. The recent HIV seroprevalence projections for racial and ethnic communities also points to a strong need of continuing to develop structures and systems to support the growing rate of HIV infected people of color. I would strongly encourage each of you to review these documents again as you go through the process.

Thank you in advance for your attention to this matter. If you have further questions or comments, please feel free to contact me at your convenience.

Sincerely,

Rafael Chang
Public Policy Director

cc: American Indian AIDS Institute
Black Coalition on AIDS
Latino Coalition on AIDS/SIDA
file

A / P A C Asian / Pacific AIDS Coalition Dept 513, P.O.Box 597004, San Francisco, CA 94159
Admin. Office: 995 Market St., Ste. 1112, San Francisco, CA 94103 Tel. 415/243-8909 Fax 415/243-8628

DOCUMENTS DEPT.
OCT 01 1993
SAN FRANCISCO
PUBLIC LIBRARY

HIV HEALTH SERVICES PLANNING COUNCIL

October 4, 1993

25 Van Ness Ave., Third Floor Conference Room

4:30 to 7:30 p.m.

AGENDA:

I. Roll Call

II. Review of September 20th Meeting Minutes and Agenda

III. General Announcements

IV. Subcommittee Reports

V. Presentation of Estimated HIV+ Population in San Francisco

VI. Client-Based Needs Assessment (Questionnaire) Results

VII. Review of "Special Populations"

VIII. Review & Critique of September 27 Public Hearing

IX. Review of Existing Services

X. Discussion of Method for Reprioritizing CARE Services

XI. Public Comment

o/wp/brand/pcagend. (P 4)

F
22
2
10/4/93

DOCUMENTS DEPT
OCT 22 1993
SAN FRANCISCO
PUBLIC LIBRARY

HIV HEALTH SERVICES PLANNING COUNCIL

October 4, 1993

25 Van Ness Avenue, Third Floor

4:30 - 8:00 p.m.

MINUTES

MEMBERS

Present: Marcy A. Fraser, Yvonne Frazier, Barbara Garcia, Estela Garcia, Jaime Geaga, Gifford S. Leoung, Steve Lew, Kent Macdonald, Scott Miller, J.B. Molaghan, Bob Nelson, Elliot S. Ramos, Steve Roger, Mike Shriver, Laura Thomas, Rita Times, Jerry Windley, Mary Jane Wood.

Absent: Pat Christen, Susan Karp, Lester D. Hanson, Gerald Lenoir, James Loyce, Jr., Reggie Williams.

Staff Present: Sophia Chang, Valerie Dorr, Teri Dowling, Mitch Katz, George Lemp, David Markofsky, Rani Marx, Mark Morewitz, Susan Williams, Charles Brand.

I. Roll Call

Roll call was taken as above. Both chairpersons were absent, and the Members designated Estela Garcia to serve as temporary Chairperson. Accordingly, she did not vote on resolutions considered during the meeting.

II. Review of Minutes and Agenda

The minutes of September 13, 1993, were corrected as follows: Steve Roger abstained from the motion to accept the Subcommittee report to place the Health Outreach Team on probation [Item V]. The revised minutes, the minutes of September 20, 1993, and the agenda of October 4, 1993, were accepted, with none opposed and the following Members abstaining: Estela Garcia, Steve Lew, Elliot Ramos and Michael Shriver.

III. General Announcements

•Co-chair Reggie Williams has requested a six-week leave of absence effective today, for reasons of health.

•Mike Shriver reported that the final HOPWA budget represents a $156.3 million increase. With nine new cities added to the list, a $149 million increase would be the equivalent of last year's level. Next year's Title I funds will represent an increase of at least $133 million, possibly $143 million. San Francisco's formula funds will be approximately $19.5 million.

•Bob Nelson reported on the AIDS Housing Conference in Chicago last week, which Bill Haskell and 11 others from San Francisco attended -- among up to 400 persons from 47 states. Bill presented several well-received papers. San Francisco appears to be the only city on target with HOPWA planning. No other EMA has achieved so much coordination between planning council and local public health and redevelopment agencies.

•Dr. Mitchell Katz advised the Planning Council that Catholic Charities, the sole bidder, was awarded the Shanti House contract. On October 6 the AIDS Office will host a reception at Shanti House for CBO's and residents, to facilitate the transition. Haight-Ashbury and Baker Places bid on the Shanti congregate flats contract, and the latter was awarded all ten congregate flats. On November 1, Visiting Nurses and Hospice will begin to operate Shanti's 24-hour house, which is their third 24-hour unit. All these CBO's are highly experienced, and there should be no breaks in service.

A new provider for Shanti housing subsidies is yet to be determined. The AIDS Office is trying to coordinate this program with HOPWA subsidies.

The HIV Housing Network will now become "CHIPS," the Centralized Housing Information Placement Service. Persons need enter only a single agency -- the CBO of their choice,-- to automatically receive comprehensive, updated information on all available housing. Case managers perform intake using a uniform assessment form. Clients will only be assessed once in order to be put onto appropriate waiting lists for housing.

The AIDS Office met with many CBO's to discuss how CHIPS might serve persons with skilled nursing needs. A single intake will be tremendously beneficial for discharge planning and client placement.

•Catholic Charities feels that multiple-diagnosed clients are best served by congregate housing. Those with fewer needs prefer to remain at home, with any subsidization necessary. Therefore they may request higher unit-of-service reimbursement. Bob Nelson states that Catholic Charities would never force out a client to accommodate a triple-diagnosed patient.

The•Shanti Project has partially complied with the AIDS Office request for audited statements. Their deadline was October 1. They submitted an unaudited 1990-1991 report of actual expenditures, prepared by their internal controller. They also submitted a letter from their outside auditor verifying that Shanti's administrative and personnel situation precluded an independent audit by October 1. Shanti requested a 90-day extension. This was granted, and the probationary term was likewise extended. This means that the Shanti Project cannot apply for funds as a primary agency for 90 days, but could do so as a subcontractor. The 1992-1993 report has not been received, but no problems are anticipated for that year. Much of the questioned 1991-1992 expenditure of $420,000 did not go to housing services, and must be repaid.

IV. Subcommittee Reports

•Marin County AIDS Commission and San Mateo County AIDS Advisory Board have formally nominated Geoffrey Sackett and A. Gene Copelo, MD, to the Planning Council. They may vote after formal appointment by the Mayor.

•Pat Christen's notes on the co-chair position were distributed to the Members. They will be discussed on October 18.

V. Presentation of Estimated HIV+ Population in San Francisco

Dr. George Lemp reviewed the document *Estimates of the Number of Persons Infected with HIV in San Francisco by Race & Ethnicity (see Attachment 1A.)*

Q.- Has the Surveillance Branch changed its projections of HIV-infected persons in San Francisco since its last presentation to the Planning Council?
A.- Our projections have not changed this past year. San Francisco still has the highest per capita incidence. It will also be the first city to experience epidemic peak and decline. The absolute total should also decline. This will be demonstrated in the December estimates. This peak reflects 1981-1982 infections. The Center for Disease Control still has not grappled with the subject of epidemic peak. Last year it postulated a two-year window, and that a flat-level epidemic would continue nationwide.

•Dr. Lemp noted that the Surveillance Branch had begun to accumulate data on lesbian and bisexual female infection. The information will be presented on October 19 to the Health Commission, and discussed before then with the Planning Council. Ten persons in this classification had AIDS, of whom seven are alive. Dr. Sophia Chang noted that reported casesof AIDS among transexuals are reported by the CDC as men (sex at birth).

VI. Client-Based Needs Assessment (Questionnaire) Results

Sophia Chang and Rani Marx reviewed the draft *Summary Report* and additional charts (see *Attachment 1D*). They designed the project; and AIDS Office staff, particularly Susan Williams, Mark Morewitz, and Alba Barreto, handled all the data. Many CARE CBO's and other providers distributed the surveys, and the Visiting Nurses and Hospice and Project Open Hand programs brought surveys to the homebound. Respondents wrote in these areas of priority service needs:

⇒54%	Living expenses (money, food, miscellaneous)
⇒38%	Mental health services
⇒29%	Practical support
⇒28%	Medical care & coverage
⇒20%	Housing
⇒ 8%	Alternative medicine
⇒ 7%	Substance abuse treatment
⇒ 4%	Information services
⇒ 2%	Outreach, or new population services

Susan Williams noted that every participating agency will receive a site-specific report. In the "Comments" section, Mark Morewitz has digested the remarks of many respondents who felt that they had to amplify the generalized survey responses.

The Council applauded the AIDS Office staff for their work.

VIII. Review of "Special Populations"

The Council discussed whether to add any "special population" categories to the four required by HRSA. Dr. Sophia Chang noted that *each* category requires detail about the situation in each of the three counties, and the effect of services. The final selection does not restrict the Planning Council's activity; but only specifies which additional reporting requirements it voluntarily accepts and mandates for itself. Accepting all of the Council's 28 target groups (See *Attachment 1G*) as special populations, would put an inordinate strain on AIDS Office and deflect it from more urgent activity.

Some Members wished to specify "Youth" and "Homeless" categories. Mike Shriver noted that CARE may become the only resource for HIV+ undocumented aliens. Geoffrey Sackett noted that Marin could only report on the four categories plus youth and homeless.

The following motion was made, seconded, and approved without opposition or abstention:

> **That the Planning Council adds the special population categories of "Youth" and "Homeless" to the four basic categories required by HRSA.**

VIII. Review & Critique of September 27 Public Hearing

Charles Brand distributed a précis of public comments made at the September 27 Public Hearing, with a chart indicating the distribution of identified service gaps (see *Attachment Two*). The deadline for receipt of written comments is today, October 4. These will be summarized and presented to the Planning Council on October 18.

IX. Review of Existing Services

(See *Attachment 1F.*) Susan Williams extrapolated this information from the AIDS Office data base.

X. Discussion of Method for Reprioritizing CARE Services

Dr. Sophia Chang informed the Council that it must prioritize CARE services according to the HRSA categories, which differ significantly from those previously used. (See *Attachments 1G & 1H* for the HRSA Application layout; the definition of HRSA categories and subcategories will be sent separately.) Last year's application was criticized for not prioritizing as requested, but only increasing the previous year's allocation amounts.

XI. Public Comment

•Rafael Chang, Public Policy Director of The Asian/Pacific AIDS Coalition, requests that Council Members review the 1992 document *People of Color and HIV/AIDS: Planning for Treatment and Services in San Francisco,* which has been endorsed by several POC groups. In view of recent HIV seroprevalence projections, the document can inform the Members when prioritizing services *(see Attachment Five).*

•Joe Gonzales discussed the effect of major Department of Mental Health & Substance Abuse Services [DMS] programmatic changes on services to HIV clients. DMS narrowed the definition of service eligibility. Access is determined by evaluation on a point system. Active clients must score 6 points to continue, prospective clients 9 points to enter. Many HIV clients have major mental health issues, especially depression, but would not normally qualify for services without the Ryan-White funds that allow DMS more flexibility. Providers are referring back to DMS an increasing number of HIV clients who no longer meet DMS criteria. Many are on psychiatric medications.

Mr. Gonzales asked the Planning Council and AIDS Office to take the lead in defining Mental Health and mental illness issues for the HIV community. He requested the Surveillance Branch to provide DMS with statistics on the mental health needs of the HIV population. Surveillance does not accumulate this data.

•Gail McBride of the Family Service Agency of San Francisco, a CARE-funded agency, and president of the HIV Contractors Association, discussed the agency's activities, and the effect of DMS programmatic changes. Since July 1 many are no longer admitted unless they display a severe symptomology. This could jeopardize the agency's three-year-old unique partnership with private practitioners and DPH. Clients are referred to an appropriate practitioner, who charges only for the actual face-to-face time. Currently 135 providers offer individual therapy and crisis intervention. The crisis intervention component offers 15 sessions. The individual therapy component is being kept open for Medi-Cal clients who do not qualify for DMS services.

This past year the AIDS Office insisted on increasing the number of group therapy activities, but these are already adequate. These numbers can be revisited in the next roundof contract negotiations. However, the AIDS Office is insisting on maintaining the number of clients to be served. Ms. McBride also noted that providers still used the DMS pharmacy program, and hopes that it will remain available. Ms. McBride was surprised to learn of the low (5%) administrative overhead amount allowed by CARE grants. Mike Shriver recommended inviting DMS deputy director Dr. Jeffrey Jue to address the Council on the DMS two-tier services level.

ATTACHMENTS:

(1) All members received a Notebook with the following contents:
(A) Estimates of the Number of Persons Infected with HIV in San Francisco by Race & Ethnicity, DPH Aids Office/ Surveillance Branch, 6/28/93.
(B) HIV Seroprevalence Reports: *Table 1. Estimated HIV Population by Ethnicity, Gender and Age in San Francisco as of June 30, 1993; Table 2. Estimated HIV+ Population by Transmission/ Risk Category in San Francisco as of June 30, 1993: 2a. Estimated Adult HIV+ Population; 2b. Estimated Pediatric HIV+ Population.*
(C) Client Focus Group Findings (too be provided 10/11)
(D) Client-Based Needs Assessment – Summary Report [Draft]. Sophia Chang, 10/4/93. Three additional charts were distributed, to be attached to the *Report.*
(E) Provider Focus Groups. Teri Dowling, 10/4/93.
(F) Review of Existing Programs. Susan Williams, 10/4/93.
(G Target Population Categories. (Original Special Populations List).
(H) Instructions for Completing Table 3, 7/30/93. (Blank) *Table 3: Estimated Number of People Needing Specific Services, by Gender and Age,* 7/30/93; *Table 4: Qualitative Assessment of Populations with Special Needs,* 7/30/93. Part of HRSA Report due 10/31/93)

(2) *HIV Health Services Planning Council Public Hearing: September 27, 1993.* Charles Brand 10/4/93.

(3) Letter: Rafael Chang to HIV Health Services Planning Council Members, c/o Dr. Sophia Chang, 10/1/93.

NEXT PLANNING COUNCIL MEETINGS:

Monday -- October 11, 1993 -- 3:00--9:00 p.m.

Monday -- October 18, 1993 -- 4:30--7:30 p.m.

Monday -- October 25, 1993 -- 4:30--7:30 p.m.

o/wp/brand:/pcl104.doc – 10/11/93 13:41

DOCUMENTS DEPT.
OCT 8 1993
SAN FRANCISCO
PUBLIC LIBRARY

HIV HEALTH SERVICES PLANNING COUNCIL
October 11, 1993
25 Van Ness, Third Floor Conference Room
3 to 9 p.m.

AGENDA

I. Roll Call

II. Review of Minutes and Agenda

III. General Announcements

IV. Subcommittee Reports

V. Presentation of Client Focus Group Findings--The Support Center

VI. Review of and Update on HOPWA Fund Allocations

VII. Priority Setting for ALL CARE-funded Services

VIII. Development of New Funding Priorities:
--Decisions re: Augmentation of Existing Programs vs. New Programs

IX. Public Comment

10113aao

SF

11

HIV HEALTH SERVICES PLANNING COUNCIL

October 11, 1993

25 Van Ness Avenue, Third Floor

3:00 - 8:30 p.m.

111 MINUTES

OCT 20 1993
SAN FRANCISCO
PUBLIC LIBRARY

MEMBERS

Present: Pat Christen, Marcy A. Fraser, Yvonne Frazier, Barbara Garcia, Estela Garcia, Jaime Geaga, Lester D. Hanson, Susan Karp, Gerald Lenoir, Steve Lew, James Loyce, Jr., Kent Macdonald, Scott Miller, J.B. Molaghan, Bob Nelson, Elliot S. Ramos, Steve Roger, Mike Shriver, Laura Thomas, Jerry Windley, Mary Jane Wood.

Absent: Gifford S. Leoung, Rita Times, Reggie Williams.

Staff Present: Sophia Chang, Valerie Dorr, Bill Haskell, Charles Brand.

I. Roll Call

Roll call was taken as above. The Members designated Mike Shriver to serve as temporary Chairperson. Accordingly, he did not vote on resolutions during the meeting.

II. Review of Minutes and Agenda

The minutes of October 4, 1993, and the agenda of October 11, 1993, were accepted, with none opposed. These Members abstained: Pat Christen, Estela Garcia and Gerald Lenoir.

III. General Announcements

There were no general announcements.

IV. Subcommittee Reports

There were no subcommittee reports.

V. Presentation of Client Focus Group Findings -- The Support Center

Mike Allison of The Support Center for Nonprofit Management, presented the Planning Council with the draft report of their preliminary findings (see *Attachment Eight*). Other Support Center consultants joining him in the presentation were Brenda Crawford, Juan Cruz, Richard Fowler, Paul Lairson, Jeff Stryker and Tim Wu.

This information was obtained from focus groups of HIV+ persons and with providers. The Support Center staff reviewed the basic findings of the study (see *Attachment Nine*), and summarized them as follows:

POSITIVE EXPERIENCES
Strengths of Current System

- ☒Clients Appreciate Providers
- ☒Wide Range of Services
- ☒Value of Case Manager
- ☒Culturally Specific Groups
- ☒Choice of Services & Providers

NEGATIVE EXPERIENCES
Weaknesses of Current System

- ☒Interactions with Providers
- ☒Information + Decision Making
- ☒Access
- ☒Availability of HIV Services
- ☒Lack of Other Basic Services
- ☒Lack of Motivation to Use Services
- ☒Distrust of Providing Community
- ☒Desire to Contribute

HIERARCHY of NEEDS
For a Customer-Focused System

- ☒To Be Treated With Compassion & Respect
- ☒Reliable, Comprehensive Information About Treatment & Service Options
- ☒Streamlined Access to Comprehensive System of Care
- ☒Help With Non-HIV Specific Needs
- ☒Systemic Incentives to Reward Health
- ☒Outreach
- ☒Opportunities to Contribute

Participants often expressed gratitude for the assistance they received. They acknowledged the complexity of building an effective comprehensive continuum of care, and the good efforts put forward to achieve this. Many noted that they had moved to San Francisco to take advantage of the superior services here. Those assisted by case managers experienced less frustration in locating and accessing the services they required. There was widespread interest in streamlining access and having some choice (but not an overwhelming number of options).

Q.- Did focus group participants mention discrimination in accessing services?
A.- Discrimination was most frequently mentioned by Latinas, Latino heterosexuals and transgenders. The latter seemed to feel particularly isolated and discriminated against. It was also expressed about providers who base access on T-cell count levels. Some thought that this was arbitrary. These services were usually the most expensive, or the most difficult to access.

Q.- Was there a uniform understanding of the role of "case managers?"
A.- The term was used inconsistently. Social workers were commonly perceived as "case managers." Sometimes a client viewed any provider with whom (s)he had developed a relationship, as a case manager. There is either a pronounced shortage of case managers, or they are not very accessible. Many providers who were not case managers were often forced into this role by circumstances. They took this client expectation seriously, and wished to know more about available services.

Q.- Were there any unexpected findings?
A.- •A widespread feeling of discrimination. Some gay males felt that the number of services available to them is disproportionate to their percentage of the HIV+ population. Transgenders were particularly upset. Women were generally very satisfied with service availability. •The belief that HIV+ status improved societal and economic status. Persons were going to great lengths to enter the system. •The informality of the system. At times access criteria seemed arbitrary, and providers proprietary.

Planning Council Members were asked to review the draft report and inform the Support Center if they wished other information included in the final report. The latter will also include Jeff Stryker's research. Stryker surveyed existing literature to determine the extent that other models or experiences can inform their report.

VI. Review of and Update on HOPWA Fund Allocations
Bill Haskell reviewed the efforts in Housing (see *Attachment Six*). He advised the Planning Council to review its policy of reserving as much HOPWA funding as possible for capital development; by funding overhead and services with CARE funds. This meant that a progressively larger proportion of CARE funds would be captured by these Housing support services. Bill conveyed the recommendations of the AIDS Office and Redevelopment Agency to the Planning Council, to support existing HIV housing programs and facilitate the development of new HIV housing. They must be formally considered and acted upon within the next month (see *Attachment Seven*).

VII. Priority Setting for all CARE-funded Services.
The Council must prioritize all CARE services, using the 17 HRSA categories rather than those previously used. To assist the Members in making the transition to the new categorization system, Sophia Chang distributed the following: (1) a worksheet which demonstrates how the HRSA categories would generally fit under the previously-used six-tier scheme (see *Attachment Two*); (2) a review of *existing* programs, broken down by HRSA categories (see *Attachment Three*; note that this information *does not* include the AIDS Drug Assistance Program (ADEP) program in Marin and San Mateo Counties); (3) service needs based on client needs assessment studies, broken down by HRSA category (see *Attachment Four*); (5) prioritization lists of needs and unmet needs, based on various sources, and arranged according to HRSA categories (see *Attachment Five*); and (6) 1992-1993 utilization data, broken down by HRSA categories (see *Attachment 5A].*

Dr. Chang noted that some of the old categories are often spread between two or more HRSA categories. Some are now a separate category (*eg.*, Hospice Care). Traditional (Alternative) medicine was no longer a distinct category, although the Council could resolve to remove it from the HRSA catch-all "Other" category and list it separately. The HRSA

"Housing" category includes many services that the Council previously included in Primary Care, Other Health Care, or Psychosocial, but no longer includes Substance Abuse Treatment. Other HRSA category intricacies to be noted, are:

HRSA Category	***Includes:***
(4) *Case Management*	☑A large gray area. Overlaps with Client Advocacy (15).
(6) *Rehabilitation*	☑Dementia care, low vision training, speech pathology, etc.
(7) *Substance Abuse*	☑Residential care.and outpatient treatment.
(10) *Buddy/ Companion*	☑One-on-one emotional support; also group therapy by non-licensed providers.
(11) *Day/ Respite Care*	☑Children.
(12) *Direct Emergency Assistance*	☑Much more than housing vouchers.
(15) *Client Advocacy*	☑Legal assistance, benefits counseling.
(17) *Information*	☑Outreach, information services.

The Planning Council's prioritization criteria for the *continuum of care* have been:

PRIORITIZATION CRITERIA

- ☒Survival services -- that keep people alive/ stable
- ☒Increasing access to system
- ☒High client need
  - •Number of service users (UDC #'s)
  - •Previously neglected population
  - •Scope & intensity of need
- ☒Full-spectrum of disease
- ☒Service for low-income/ uninsured
- ☒Cost-effectiveness
- ☒Otherwise unreimbursable
- ☒Capacity building/ enhancement

The Council discussed these issues. The following motions were made and seconded:

To include Information Services and Outreach under the "Client Advocacy" category.

To include Money Management and Representative Payee services under the "Case Management" category.

To establish additional, separate categories for (1) "Alternative/ Complementary/ Conventional Medical Care" and (2) "Translation/Interpretation".

All three motions were seconded and approved, without opposition or abstention.

Council members divided into four groups and prioritized CARE-funded services by consensus process within each group. The four lists were then summarized, with these results:

PRIORITIZATION of CARE-Funded Services

HRSA # & Category	*RANK*	I.	II.	III.	IV.	*Average*
1 -Primary	1	1	1	1	1	1.00
14-Housing	2	2	3	2	2	2.25
13-Food	3	3	4	3	6	4.00
2- Dental	4	4	2	7	7	5.00
3- Mental Health	5	5	8	4	3	5.00
4- Case Mgt.	6	7	6	6	4	5.75
7- Substance Abuse	7	6	5	8	5	6.00
5- Home Health	8	11	7	9	8	8.75
15-Client Advocacy	9	8	10	10	9	9.25
12-Direct Emergency	10	13	9	5	11	9.50
(17)-Alternative Medicine	11	10	11	13	12	11.50
10-Buddy	12	9	12	12	13	11.50
8- Hospice	13	12	13	11	10	11.50
6- Rehabilitation	14	14	14	15	14	14.25
11-Day/ Respite Care	15	16	15	17	15	15.75
16-Transportation	16	17	16	14	17	16.00
(18)-Translation	17	15	17	16	16	16.00
9- Support Services	18	18	18	18	18	18.00

Tabulation of the four lists resulted in several "ties" that were discussed and resolved by Planning Council resolution.

The following motions were made, seconded, and approved unanimously:

"Primary Medical Care," "Housing" and "Food" shall be the First, Second, and Third service priorities, in that order.

"Dental Care" and "Mental Health Therapy/Counseling" shall be the Fourth and Fifth service priorities, in that order.

"Case Management," "Substance Abuse Treatment/Counseling," "Home Health Care," "Client Advocacy" and "Direct Emergency Assistance" shall be the Sixth, Seventh, Eighth, Ninth and Tenth service priorities, in that order. "Case Management" shall include money management and representative payee services; "Client Advocacy" shall include information and outreach services.

The following motion was made and seconded:

> "Alternative Medical Care," "Hospice Care" and "Buddy/Companion Services" shall be the Eleventh, Twelfth and Thirteenth service priorities, in that order.

Four Members voted for the resolution and 10 were opposed. The motion failed.

The following motion was made and seconded:

> **"Alternative Medical Care," "Buddy/Companion Services" and "Hospice Care" shall be the Eleventh, Twelfth and Thirteenth service priorities, in that order.**

The motion was adopted, 10 Members voting for it, and 4 Members opposed.

The following motions were made, seconded, and adopted unanimously:

> **"Rehabilitation Care" and "Day/Respite Care" shall be the Fourteenth and Fifteenth service priorities, in that order.**
>
> **"Transportation" and "Translation/ Interpretation" shall be the Sixteenth and Seventeenth service priorities, in that order.**
>
> **"Support Services" shall be the Eighteenth service priority.**
>
> **The Planning Council sets its service priorities according to the order in the aforesaid resolutions.**

VIII. Development of New Funding Priorities: Decisions re: Augmentation of Existing Programs vs. New Programs

Sophia Chang discussed the work that the Planning Council must complete during this meeting and that of October 18 (see *Attachment One*). Today (October 11) the emphasis was on *planning rather than advocacy*, on *prioritization rather than allocation.* The Council planned a continuum of care, and did *not* focus on gaps in service or emphasizing target populations. On October 18, the Council's work *will* emphasize (1) review of service gaps and special population needs; and (2) prioritization of *new* programs and continuation of existing programs. Members were advised to review all the utilization reports and surveys, and be prepared to finalize the RFP. The main challenge will be to handle effectively the growth in funding, how to effectively allocate additional funds, and to decide where to augment existing programs, and when to approve new ones.

XI. Public Comment

There was no public comment.

ATTACHMENTS:

(1) *Review of October 11 Meeting; Review of October 15 Meeting.*
(2) *San Francisco's Continuum of HIV Services: Services for HIV-Infected Persons.*
(3) *Review of Existing Programs: Summary of Clients Served in E.M.A.*; and *Breakdown of HRSA Categories by Agencies and Programs (EMA).*
(4) *Estimated Total # of Persons Needing Services in EMA.*
(5A) *1992-1993 Quarterly Report Utilization Data of Service Categories; Budgeted Versus Actual Unduplicated Clients Served 1992-93.*
(5) *Review of Need and Unmet Need Data*
(6) *Project Summary - 1992 HOPWA Funds San Francisco EMSA; Summary of 1993 HOPWA Requests by Category.*
(7) Memorandum: Bill Haskell to HIV Health Services Planning Council, *Recommendations for the use of CARE & HOPWA funds for HIV Housing Development plus Supportive Services and Operating Expenses,* 10/11/93.
(8) The Support Center for Nonprofit Management, *What Do the Clients Say?, (San Francisco, 1993),* 65 pp. Copies available from the Department of Public Health, AIDS Office/ Health Services Branch, 25 Van Ness Avenue, San Francisco, CA 94102.

NEXT PLANNING COUNCIL MEETINGS:

Monday -- October 18, 1993 -- 4:00--8:00 p.m.

Monday -- October 25, 1993 -- 4:30--7:30 p.m.

o/wp/brand:/pcl104.doc 10/15/93 10:06

ATTACHMENT ONE

Review of October 11th Meeting

- Goals of the Meeting (What needs to get accomplished)
- Review of Service Continuum (How it overlaps with HRSA service categories)
- Review of Existing Data
  - Summary Table of Consumer Data
  - Surveillance Data
  - Provider Data
  - Public Hearing
- Review of Prioritization Criteria
- Focus Group Presentation (Support Center)
- Break-out Into Small Groups to Determine Consensus Priorities
- Review of Small Group Information and Full-Group Consensus on Service Priorities

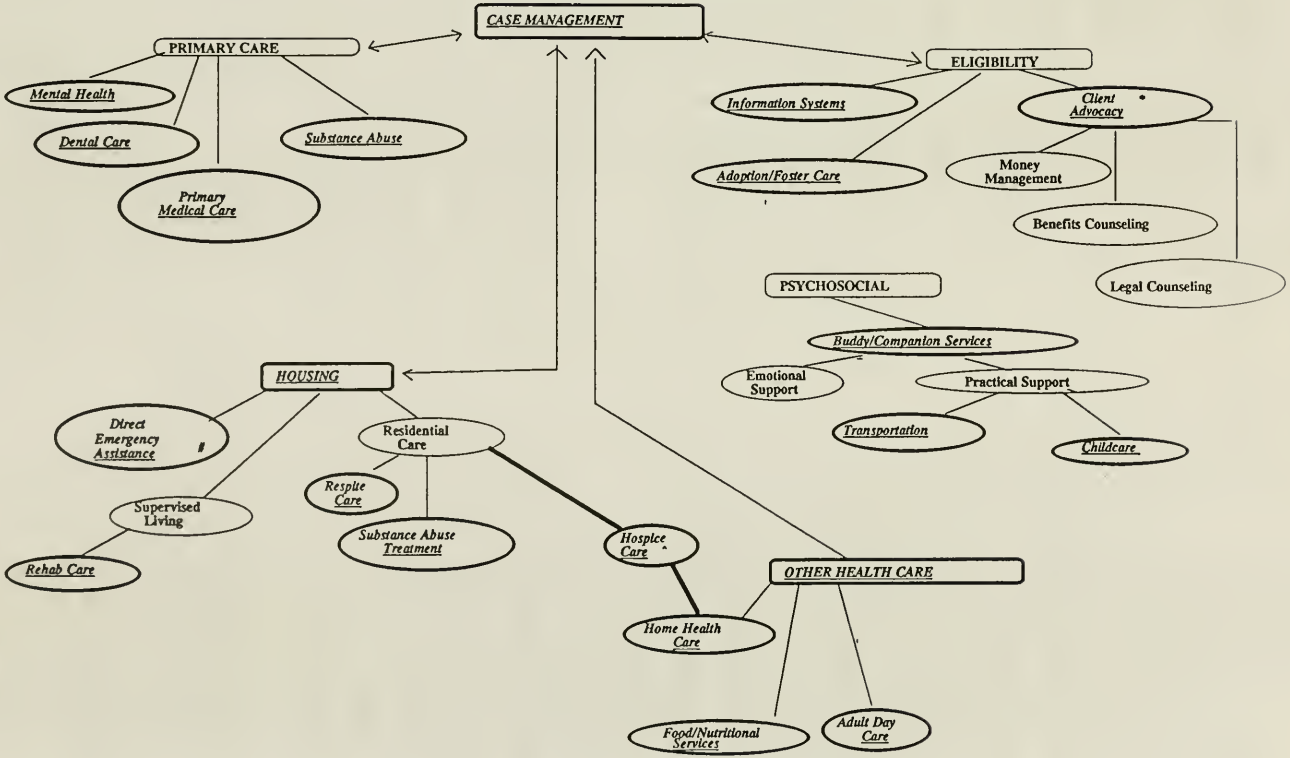
---

Review of October 15th Meeting

- Review of Unmet Needs
- Priorities for New/Continuing Services
- What to Bid
- Who Can Bid
- Under What Terms
- How Much Money

SAN FRANCISCO'S CONTIUNUM OF HIV SERVICES

Services for HIV-Infected Persons



BOLDED categories=HRSA Categories

* Client Advocacy was previously under Psychosocial

Emergency (Housing) Assistance was previously not a separate category

^ Hospice care consists of residential Hospice care and home hospice nursing care

TWO

ATTACHMENT THREE

REVIEW OF EXISTING PROGRAMS: SUMMARY OF CLIENTS SERVED IN E.M.A.

	HRSA CATEGORY	NUMBER PROGRAMS FUNDED	NUMBER AGENCIES REPRESENTED	NUMBER OF UDC [Unduplicated Clients]	TOTAL AMOUNT CONTRACTED	% OF TOTAL	AVERAGE COST PER UDC PER YEAR
1	Primary Medical Care	23	16	7812	$10,026,731	31.0%	$1,284
2	Dental Care	1	1	1158	$505,607	1.6%	$437
3	Mental Hlth Therapy & Counseling	20	13	3601	$2,467,450	7.6%	$685
4	Case Management	17	11	2623	$2,367,336	7.3%	$903
5	Home Health Care	10	4	562	$1,788,657	5.5%	$3,183
6	Rehabilitation Care	3	3	87	$767,773	2.4%	$8,825
7	Sub. Abuse Treat. & Counseling	22	11	1992*	$4,490,764	13.9%	$2,254
8	Hospice Care	4	2	234	$1,812,680	5.6%	$7,746
9	Adoption/Foster Care Assistance	1	1	35	$108,110	0.3%	$3,089
10	Buddy/Companion Services	9	6	1577	$982,364	3.0%	$623
11	Day and Respite Care	5	4	213	$342,258	1.1%	$1,607
12	Direct Emergency Assistance	5	4	1989^	$1,121,857	3.5%	$564
13	Food Bank/Home Delivered Meals	6	3	1840	$1,134,622	3.5%	$617
14	Housing & Housing Related Srvs.	10	5	636^	$2,860,627	8.9%	$4,498
15	Client Advocacy	11	7	2199	$937,117	2.9%	$426
16	Transportation	3	2	865	$150,604	0.5%	$174
17	Other Support Services	10	7	6561	$460,536	1.4%	$70
				TOTAL	$32,325,093	100%	

*This figure does not include Unduplicated Clients for HAFMC - Lodestar Program or UCSF/SAS - MOTOP & Heroin Detox programs. (Contracts in development)

^This figure includes projected numbers of Unduplicated Clients from 1992-1993 contacts. (1993-1994 contracts currently in negotiation)

NOTE: This chart does not reflect $1,630,150 currently out to bid under RFP 016-93 (Psycho-Social Support Services). The final contract will include HRSA categories 3, 10 and 15.

BREAKDOWN OF HRSA CATEGORIES BY AGENCIES AND PROGRAMS (EMA)

CONTRACT AGENCY	PROGRAM	HRSA CAT	93-94 AMOUNT	# of UDC
American College of Traditional Medicine	Complementary Therapies	1	$181,077	140
Bayview Hunter's Point Foundation	Alternative Health Care	1	$93,728	50
Haight-Ashbury Free Medical Clinic	Primary Medical Care	1	$243,625	162
Institute for Traditional Medicine	Complementary Therapies	1	$214,040	160
Lyon Martin Women's Clinic	Primary Medical Care	1	$188,100	68
Mission Neighborhood Health Center	Nutrition Counseling	1	$49,502	150
Mission Neighborhood Health Center	Early Interv. Program	1	$286,595	252
Planned Parenthood/PHREDA	Medical Care	1	$155,558	120
Prof Mgmt Devlopment Corp	AIDS Drug Assistance Prog. (ADAP)	1	$2,417,065	1000
SF Community Clinic Consortium	Primary Medical Care	1	$218,405	208
SF Community Clinic Consortium	"	1	$327,608	312
SFDPH - CPHS	SPY--Primary Care	1	$135,758	60
SFDPH - CPHS	TB Control Division/Lab	1	$53,803	N/A
SFDPH - CPHS	Primary Care Services	1	$886,983	1185
SFDPH - CPHS	"	1	$1,653,315	850
SFDPH - Forensics	Early Intervention	1	$136,338	125
SFDPH - Forensics	"	1	$124,803	400
SFDPH - SFGH	Non ADAP Drugs	1	$72,624	N/A
SFDPH - SFGH	Pharmacy	1	$85,405	N/A
SFDPH - SFGH	Ward 86, AIDS Clinic	1	$474,112	600
SFDPH - SFGH	"	1	$61,730	75
SFDPH - SFGH	"	1	$34,200	300
SFDPH - SFGH	Ward 93	1	$82,296	200
SFDPH - SFGH	Early Intervention Clinic	1	$80,071	120
St. Mary's Hospital	HIV Outpatient Primary Care Svcs	1	$273,006	170
UCSF/AIDS Clinic	Women's Clinic	1	$96,474	85
Marin County	Primary Medical Care	1	$428,670	200
San Mateo County	Early Intervention/ Primary Care	1	$649,793	550
San Mateo County	"	1	$238,815	200
San Mateo County	"	1	$83,232	70
UOP/School of Dentistry	Dental Care	2	$505,607	1158
AIDS Indigent Direct Services	Client Services Program	3	$59,083	100
AIDS Indigent Direct Services	Mental Health Program	3	$65,653	200
American Indian AIDS Inst.	Crisis Intvntn/Mental Health	3	$26,125	35
Children's Hospital/CPMC	Mental Health Services/Crisis Intvtn	3	$137,909	60
Family Service Agency of S.F.	Mental Health Services	3	$207,006	155
Instituto Familia de la Raza	Psychotherapy Program	3	$36,401	20
Larkin Street Youth Center	Aftercare	3	$128,957	40
Operation Concern/CPMC	Early Intervention Psychosoc Supp.	3	$109,203	180
Operation Concern/CPMC	Outpatient Mental Health	3	$125,583	135
SFDPH - CMHS	Acute Psychiatric Services	3	$199,881	147
SFDPH - CMHS	Mental Health CM	3	$461,757	130
SFDPH - CPHS	Mutti-Diagnosis Program - HC#1	3	$265,788	100
SFDPH - SFGH	Psych. Consult/Liaison	3	$116,165	384
UCSF/AIDS Health Project	Psychiatric Consult Service	3	$67,706	340
UCSF/AIDS Health Project	"	3	$37,546	175
UCSF/AIDS Health Project	Mental Hlth Comm. Liaison	3	$54,565	200
UCSF/AIDS Health Project	Ward 86/ Mental Hlth Svcs	3	$125,256	275
UCSF/AIDS Health Project	"	3	$91,720	675
UCSF/AIDS Health Project	Volunteer Therapy Program	3	$22,429	160
UCSF/Center on Deafness	Itinerant Mtl Hlt Svcs	3	$28,502	15
UCSF/Center on Deafness	Psychosocial Services	3	$78,375	35
Marin County	Mental Health HIV Specialist	3	$21,840	40
AIDS Indigent Direct Services	Client Services Program	4	$42,955	187
AIDS Indigent Direct Services	Case Management Program	4	$136,468	110
AIDS Indigent Direct Services	Roving Case Management Program	4	$76,938	65
American Indian AIDS Inst.	Case Management	4	$35,887	25
American Indian AIDS Inst.	"	4	$35,490	25
GCHP	Case Management & Advocacy	4	$23,661	16
GCHP	"	4	$118,612	70
Health Outreach Team	Case Mgmt./Health Care	4	$128,095	170
Instituto Familia de la Raza	Psychosocial Support	4	$72,802	50
S.F. AIDS Foundation	Women's Case Management Svcs	4	$59,151	80

S.F. AIDS Foundation	Vida Y Movimiento Project	4	$109,203	94
S.F. AIDS Foundation	"	4	$76,897	66
SF Community Clinic Consortium	Case Management	4	$92,522	195
SFDPH - CPHS	Case Management	4	$237,489	525
SFDPH - CPHS	SPY--Case Management	4	$149,955	75
Tenderloin AIDS Network (TARC)	Case Management Svcs	4	$64,779	120
Marin County	Case Management	4	$507,741	400
San Mateo County	Case Management	4	$81,062	150
San Mateo County	"	4	$204,854	50
San Mateo County	Case Management-Client Assistance	4	$57,775	90
San Mateo County	"	4	$20,000	30
San Mateo County	Pediatric Case Management	4	$35,000	30
Catholic Charities	Attendant Care	5	$104,343	40
Visiting Nurses & Hospice/CPMC	Home Care Services /Ambassador	5	$229,871	29
Visiting Nurses & Hospice/CPMC	AIDS Intermittent Home Care	5	$118,430	39
Visiting Nurses & Hospice/CPMC	Home Infusion Services	5	$507,631	78
Visiting Nurses & Hospice/CPMC	Home Health Care/Tenderloin	5	$250,967	93
Visiting Nurses & Hospice/CPMC	Short-Term Attendant Care	5	$58,762	15
Visiting Nurses & Hospice/CPMC	Res Site Attendant Care	5	$227,484	77
Westside CMHC	Attendant Care	5	$100,466	40
Westside CMHC	Home Care	5	$90,887	51
Marin County	Attendant Care	5	$99,816	100
Nat. Assoc. for the Visualty Handicapd	Vision Enhancement	6	$14,000	30
St. Mary's Hospital	AIDS Dementia Unit	6	$440,273	42
Westside CMHC	Residential Care AIDS/MH	6	$313,500	15
18th St. Svcs.	O/P Subst. Abuse Couns.	7	$158,552	140
Baker Places	Trans. Res. Rx - MH(New Place)	7	$228,015	38
Baker Places	Res. Rx - Multicultural (Ferguson)	7	$482,181	53
Continuum HIV Day Services	Sub. Abuse Service	7	$76,599	50
Haight-Ashbury Free Medical Clinic	Substance Abuse Rx - Detox	7	$78,375	100
Haight-Ashbury Free Medical Clinic	Res. Sub Abu Rx f/ Women(Lodestar)	7	$244,747	*
Haight-Ashbury Free Medical Clinic	Res. Sub Abu Rx f/AA men (WARH)	7	$75,000	8
Iris Center	Outpatient Substance Abuse Rx	7	$207,629	50
Iris Center	Res. Sub Abu Rx (Arc. of Refuge)	7	$270,313	10
Salvation Army	Harbor Light/SA Rx	7	$125,429	30
SFDPH - CSAS	Substance Abuse Treatment	7	$76,294	N/A
SFDPH - CSAS	Multi-Diagnosed Detox	7	$911,649	549
SFDPH - SFGH	HIV-IDU Case Management	7	$113,054	60
UCSF/AIDS Health Project	ASAP Youth Services	7	$72,520	155
UCSF/AIDS Health Project	ASAP General Population	7	$109,203	375
UCSF/AIDS Health Project	Women's AIDS/Subst Abuse	7	$66,385	100
UCSF/Substance Abuse Services	*[Indirect Costs]*	7	$21,570	*
UCSF/Substance Abuse Services	Medical Care	7	$122,672	*
UCSF/Substance Abuse Services	STOP	7	$57,837	*
UCSF/Substance Abuse Services	Outpatient Treatment/MOTOP	7	$59,171	*
UCSF/Substance Abuse Services	Heroin Detox	7	$90,000	*
Walden House	Long-Term Residen. Drug Rx	7	$218,369	27
Walden House	"	7	$233,325	29
Walden House	Substance Abuse Rx	7	$391,875	218
Maitri AIDS Hospice	Maitri AIDS Hospice	8	$54,601	50
Visiting Nurses & Hospice/CPMC	AIDS Hospice Care	8	$1,268,950	129
Visiting Nurses & Hospice/CPMC	AIDS Hospice Care/CHH	8	$194,282	22
Visiting Nurses & Hospice/CPMC	Residential Site Care/Shanti	8	$294,847	33
SFDSS	Family Services	9	$108,110	35
American Indian AIDS Inst.	Emotional/Practical Support	10	$40,554	30
Bayview Hunter's Point Foundation	The Cadre - Emot Support Team	10	$107,239	50
Nat. Task Force on AIDS Prevention	Brothers Support Services	10	$97,375	102
Rose Resnick Center for the Blind	AIDS Related Visual Impairment Svcs	10	$35,442	75
Shanti Project	Peer Counseling	10	$233,014	620
Shanti Project	Volunteer Recruitment	10	$54,601	220
Shanti Project	Crossings - Mission/Van	10	$203,182	150
Shanti Project	Crossing - Tenderloin	10	$136,503	150
Tenderloin AIDS Network (TARC)	Emotional Support Program	10	$74,454	180

Bridge For Kids	Un Puente Para Ninos	11	$51,684	18	
Bridge For Kids	Res. Child Care/Summer Day Camp	11	$37,000	25	
Continuum HIV Day Services	Adult Day Health Care	11	$168,172	125	
Visiting Nurses & Hospice/CPMC	In-Home Respite Care	11	$81,902	30	
Marin County	Child Care	11	$3,500	15	
AIDS Emergency Fund	Housing Grants	12	$205,301	442	
AIDS Emergency Fund	"	12	$332,875	717	
S.F. AIDS Foundation	Emergency Vouchers/Flat	12	$158,614	378^	92-93
S.F. AIDS Foundation	Hotel Vouchers System	12	$105,217	200	
Marin County	Vouchers	12	$111,400	200	
Marin County	Rental Assistance	12	$208,450	52	
Project Open Hand	Delivered Meals	13	$136,503	56	
Project Open Hand	"	13	$267,128	110	
Project Open Hand	Food Bank	13	$280,539	556	
Project Open Hand	"	13	$156,750	310	
Project Open Hand	"	13	$54,459	108	
S.F. Food Bank	Food Solicitation	13	$32,621	N/A	
S.F. Food Bank	Emergency Food Box	13	$90,472	300	
S.F. Food Bank	Liquid Supplement Program	13	$12,150	N/A	
Marin County	Meal Preparation	13	$104,000	400	
Baker Places	Supportive Housing Program	14	$261,250	32	
Black Coalition on AIDS	Rafiki Transitional Housing	14	$248,196	100	
Catholic Charities	Rita da Cascia House	14	$46,778	5	
Catholic Charities	"	14	$26,244	3	
Catholic Charities	"	14	$56,785	10	
Catholic Charities	Assisted Housing Program	14	$262,052	165	
Catholic Charities	Guerrero House	14	$51,048	6	
Larkin Street Youth Center	Comp. Housing Program for Youth	14	$202,780	50	
Shanti Project	Residence Program	14	$474,160	60^	92-93
Shanti Project	Single Adult RAS	14	$40,000	10^	92-93
Shanti Project	Families Subsidies	14	$234,785	27	
Shanti Project	Shanti House	14	$522,500	68	
San Mateo County	Housing	14	$434,049	100	
AIDS Benefits Counselors	Benefits Counseling	15	$209,847	670	
AIDS Legal Referral Panel	Benefit Advocacy	15	$81,902	450	
AIDS Legal Referral Panel	Legal Assistance	15	$69,465	350	
AIDS Legal Referral Panel	Volunteer Recruitment	15	$40,935	N/A	
Bar Association of San Francisco	Immigrant HIV Assistance Project	15	$74,517	187	
Coming Home Support Services	The Catalano Project	15	$65,990	129	
Coming Home Support Services	Probate Conservatorship	15	$59,358	30	
GCHP	Volunteer Services	15	$29,952	18	
GMOC/EACH	Ind Treatment Adv	15	$102,764	175	
Mission Neighborhood Health Center	Clinical Trials Advocacy	15	$38,503	50	
Mission Neighborhood Health Center	Treatment Advocacy	15	$27,820	40	
Marin County	Client Advocacy	15	$136,064	100	
SFDPH - CPHS	Shuttle Van - CPHS	16	$40,984	450	
Shanti Project	Crossings - Mission/Van Service	16	$38,318	165	
Shanti Project	Van Service	16	$71,302	250	
FTFA	Translation Services	17	$26,125	25	
GMOC/EACH	Community Events	17	$52,294	436	
GMOC/EACH	Outreach	17	$8,746	300	
Home Care Companions	Home Care Skills Program	17	$45,320	250	
S.F. AIDS Foundation	HIV Newsletter	17	$27,170	N/A	
S.F. Suicide Prevention	Nightline Phone Crisis Hotline	17	$65,522	4000	
S.F. Suicide Prevention	Nightline Communities of Color	17	$37,620	1450	
Shanti Project	Caregivers Support Program	17	$37,620	100	
Support Center	Ryan White CARE Funds Plann. Study	17	$79,330	N/A	
Support Center	Technical Assistance	17	$80,789	N/A	
TO BE DETERMINED					
Youth Psychosocial Services			$130,000		
Youth Housing Services			$74,000		
* Unduplicated Client figure unavailable					
^ Unduplicated Client figure projected from 1992-1993 contract					

ATTACHMENT FOUR

Estimated Total # of Persons Needing Services in EMA

HRSA Categ	Service Name	% Males Needing	% Females Needing	% Children Needing	Total in Need	# being served	# not served by CARE
1	Medical	96.1%	94.6%	100.0%	32317	7812	24505
2	Dental	85.5%	83.3%	100.0%	28742	1158	27584
3	Mental**	68.9%	73.8%	75.0%	23258	3601	19657
4	Case M	48.1%	56.5%	100.0%	16322	2623	13699
5	Home Health	22.2%	24.3%	25.0%	7502	796	6706
6	Rehab	17.6%	21.4%	20.0%	5979	87	5892
7	SA Rx**	27.0%	46.6%	0.0%	9365	1992	7373
8	Hospice	incl HH	incl HH	incl HH	incl HH	incl HH	incl HH
9	Adoption	1.8%	10.9%	20.0%	743	35	708
10	Buddy	51.8%	55.3%	50.0%	17481	1577	15904
11	Day/Resp**	16.0%	28.3%	75.0%	5579	213	5366
12	Dir Emerg*	69.1%	69.1%	60.0%	23250	1989	21261
13	Food	59.6%	68.1%	75.0%	20184	1840	18344
14	Housing**	58.5%	67.0%	50.0%	19807	636	19171
15	Advocacy**	73.8%	78.5%	50.0%	24896	2199	22697
16	Transport	37.2%	49.2%	75.0%	12703	865	11838
17	Information	4.1%	3.1%		1364	?	?
18	Drug Reimb	27.8%	7.4%	100.0%	9075	1000	8075
19	Other				0		0

* Based on written-in responses

** Based on combination of separate responses

Review of Need and Unmet Need Data

Current "Priorities"	Total Needs (Client Questionnaire)	Total Needs (HRSA Table)	Total Unmet Needs (Client Questionnaire)	Total Unmet Needs (HRSA Table)	Priority Needs (Client Questionnaire)
Case Management	Medical Care	Medical Care	Medical Care	Dental Care	Financial Asst ?Emerg
Advocacy	Dental Care	Dental Care	Dental Care	Medical Care	Medical Care
Primary Medical Care	Emotional Support	Advocacy Services	Emotional Support	Advocacy Services	Housing/$ for rent
Home Health/Hospice	Food Bank/Meals	Mental Health Therapy	Mental Health Therapy	Food Bank/Meals	Mental Health Care
Substance Abuse Tx	Benefits Assistance	Food Bank/Meals	Food Bank/Meals	Direct Emergency Assist	Food
Mental Health Therapy	Mental Health Therapy	Housing Services	Direct Emergency Assist	Mental Health Therapy	Help with Benefits
Food Bank/Meals	Rental Assistance	Buddy/Companion	Rental Assistance	Housing Services	Practical Help
Housing Services	Buddy/Companion		Buddy/Companion	Buddy/Companion	Transportation Help
Direct Emergency Assist	Legal Services				Help with Housing
Drug Reimbursement	Case Management	Case Management	Case Management	Case Management	Alternative Therapy
Buddy/Companion	Transportation	Transportation	Legal Advice	Transportation	Legal Services
Day/Respite Care	Housing Placement/Info	Subst Abuse Treatment	Benefits Assistance	Drug Reimbursement	Case Management
Case Management	Money Management	Drug Reimbursement	Transportation	Subst Abuse Treatment	Help Getting HIV Drugs
Resid Subst Abuse Tx	Practical Support	Home Health/Hospice	Housing Placement/Info	Home Health/Hospice	Money Management
Housing Services	Outpt Subst Abuse Tx		Money Management		Home Health Services
Day/Respite Care	Home Health/Hospice		Practical Support		Rehab Services
Hospice Care			Outpt Subst Abuse Tx		Childcare
Dental Care			Home Health/Hospice		Day/Respite Care
Medical Care	Rehab Care	Rehabilitation Care	Day/Respite Care	Rehab Care	Foster Care/Custody
Outpt Subst Abuse Tx	Day Health Care	Day/Respite Care	Rehab Care	Day/Respite Care	
Mental Health Therapy	Resid Subst Abuse Tx	Foster Care/Adoption	Resid Subst Abuse Tx	Foster Care/Adoption	
Food Bank/Meals	Childcare		Foster Care/Adoption		
Buddy/Companion	Foster Care/Adoption				
Emot Support Groups					
Foster Care/Adoption					
Housing					
Subst Abuse Tx					
Complementary Care					
etc. (see next page)					

ATTACHMENT FIVE

5-2

Food Bank/Meals
Medical Care
Mental Health Therapy
Home Health/Hospice
Resid Subst Abuse Tx
Mental Health Therapy
Dental Care
Medical Care
Substance Abuse Tx
Housing
Direct Emergency Assist
Home Health/Hospice
Food Bank/Meals
Medical Care
Emotional Support
Client Advocacy
Rehab Services
Child Care
Case Management

SA-2

REVISED DEFINITION OF CALCULATIONS FOR GENDER/AGE AND ETHNICITY TABLE

The percentage of adult males, adult females, and Others using services is based on quarterly report data from 1992-93 and distributes those individuals who were reported as Male, Female or Other (including transgender). The total number of individuals receiving each category of service was used as the denominator.

The percentage of children is based on those individuals for whom age were reported on quarterly reports as being between 0 and 12 years of age. The total number of individuals in all age groups receiving each category of service was used as the denominator.

For the categories of ethnicity, all quarterly reports that reported ethnic distribution of clients were used. The categories are self explanatory with "other" being used for individuals who reported mixed ethnicity. The total number of individuals of all ethnicities receiving each category of service was used as the denominator.

ATTACHMENT 5A

1992-93 QUARTERLY REPORT UTILIZATION DATA OF SERVICE CATEGORIES

GENDER/AGE

	Adult Male	Adult Female	Child	Other
Total EMA Est. % HIV Infected	*95.6%*	*4.3%*	*0.1%*	*N/A*
Category of Need	% Who Used*	% Who Used*	% Who Used*	% Who Used*
Primary Medical Care	84.5%	15.2%	0.3%	0.2%
Dental Care	95.1%	4.6%	0.1%	0.2%
Mental Health Therapy/Counseling	89.7%	8.8%	0.0%	1.3%
Case Management	84.7%	13.7%	1.5%	1.0%
Home Health Care	92.1%	6.6%	0.0%	1.3%
Rehab Care	94.1%	5.9%	0.0%	0.0%
Substance Abuse Rx/Counsel	80.3%	17.3%	0.1%	2.2%
Hospice Care	94.1%	5.7%	0.3%	0.3%
Adoption/Foster Care	16.7%	83.3%	12.2%	0.0%
Buddy/Companion Services	84.6%	11.6%	2.5%	2.9%
Day/Respite Care	78.9%	20.7%	16.4%	0.4%
Direct Emergency Assistance	88.4%	9.6%	0.8%	1.5%
Food Bank/Home Del.	90.6%	8.6%	0.3%	0.1%
Housing/Related Services	89.6%	8.5%	1.4%	1.6%
Client Advocacy	91.7%	6.3%	0.3%	0.7%
Transportation	89.6%	8.1%	1.8%	1.8%
Other Support Services	75.8%	24.0%	0.1%	0.1%
ADS Drug Assistance Program	96.8%	3.2%	0.0%	0.0%

ETHNICITY

	White	Afri. Am.	Latino	Asian/PI	Nat. Am.	Other
Total EMA Est. % HIV Infected	*61.7%*	*17.1%*	*13.4%*	*7.8%*	*0.6%*	N/A
Category of Need	% Who Used*	% Who Used*	% Who Used*	% Who Used*	% Who Used*	% Who Used*
Primary Medical Care	55.7%	21.0%	15.6%	3.0%	1.5%	1.1%
Dental Care	67.9%	10.9%	7.6%	2.7%	1.8%	1.6%
Mental Health Therapy/Counseling	68.9%	17.7%	7.6%	2.6%	1.6%	0.7%
Case Management	40.2%	29.5%	21.5%	4.0%	2.6%	1.1%
Home Health Care	62.4%	18.6%	17.3%	1.4%	0.3%	0.0%
Rehab Care	70.0%	22.0%	6.0%	2.0%	0.0%	0.0%
Substance Abuse Rx/Counsel	54.5%	30.8%	9.8%	1.0%	1.5%	1.1%
Hospice Care	74.8%	12.6%	8.5%	3.3%	0.3%	0.3%
Adoption/Foster Care	27.5%	55.0%	10.0%	7.5%	0.0%	0.0%
Buddy/Companion Services	64.3%	18.6%	10.0%	3.1%	1.7%	1.2%
Day/Respite Care	52.4%	18.2%	26.0%	2.2%	0.7%	0.0%
Direct Emergency Assistance	56.9%	30.8%	6.3%	1.3%	2.3%	1.4%
Food Bank/Home Del.	60.3%	23.8%	8.9%	0.8%	1.8%	1.7%
Housing/Related Services	55.2%	26.6%	9.9%	2.3%	2.9%	1.7%
Client Advocacy	65.7%	13.7%	11.0%	3.1%	1.6%	1.6%
Transportation	49.9%	32.5%	11.4%	1.6%	1.8%	1.8%
Other Support Services	59.2%	12.6%	7.7%	4.3%	1.0%	3.1%
ADS Drug Assistance Program	66.5%	10.8%	16.6%	3.5%	0.8%	0.2%

* Indicates percentage of individuals receiving services in this category.

9/ eds/genage/

BUDGETED VERSUS ACTUAL UNDUPLICATED CLIENTS SERVED 1992-93			
SERVICE CATEGORY	BUDGETED UDC	ACTUAL UDC	% ACHIEVED
Primary Medical Care	4130	3187	77%
Dental Care	750	1438	192%
Mental Health Therapy	2670	2007	75%
Case Mangement	1971	1692	86%
Home Health Care	154	219	142%
Rehabilitation Care	54	51	94%
Substance Abuse Treatment	1118	1296	116%
Hospice Care	105	107	102%
Adoption/Foster Care	35	42	120%
Buddy/Companion Care	763	632	83%
Day& Respite Care	160	239	149%
Direct Emergency Assistance	1036	1639	158%
Food Bank/Home Meals	1138	1715	151%
Housing & Related Services	929	1545	166%
Client Advocacy	1767	1845	104%
Transportation	230	232	101%

ATTACHMENT SIX

PROJECT SUMMARY - 1992 HOPWA FUNDS SAN FRANCISCO EMSA

NO.	SPONSOR	PROJECT ADDRESS	PROJECT DESCRIPTION	SUPPORTIVE SERVICE FUNDS	ACQUISITION/REHAB. OR RENTAL ASSISTANCE FUNDS	ENVIRONMENTAL REVIEW COMMENTS	
MARIN COUNTY							
1	Housing Authority of the County of Marin	Various locations	Tenant-based rental assistance	$0	$175,728 rental assistance	Exempt from ER.	
2	Community Action Marin	Various locations	Short-term payments for rent, mortgage, and utility costs	$0	$12,722 rental assistance	Exempt from ER.	
3	Hospice of Marin	Various locations	In-home attendant care	$66,000	$0	Exempt from ER.	
Total Marin County Uses:				*$66,000*	*$188,450*		
SAN FRANCISCO COUNTY							
1	Baker Places, Inc.	1249 Scott Street	12-bed community residence for homeless people with HIV/AIDS and related substance abuse or mental health problems.	$31,500	$475,000 acquisition/minor rehab	Confirm no toxics; not in flood area; not a historic landmark.	NEW
2	Bernal Heights Housing Corporation	119-121 Holly Circle	5-bed independent living environment for people with HIV/AIDS	$0	$409,550 acquisition	Confirm no toxics; not in flood hazard area.	NEW
3	Dolores Street Community Center	220 Dolores Street Hope House	10-beds for homeless people with HIV/AIDS	$0	$250,000 acquisition/rehab ($100,000 grant & $150,000 loan)	ER completed through HUD McKinney Program	NEW
4	Hartford Zen Center/ Maitri AIDS Hospice	57-61 Hartford Street Maitri AIDS Hospice	8-beds of hospice care for people with HIV/AIDS	$0	$332,500 acquisition	Confirm no toxics; not in flood hazard area.	EXISTING
5	Shanti Project	730 Fillmore Street	12-bed fully supported group home for very low income people with HIV/AIDS affected by mild or moderate dementia	$475,516	$1,089,470 acquisition/substantial rehabilitation	Confirm no toxics; not in flood hazard area; not noise impacted site; does not affect sole source aquifer; not a historic landmark.	NEW
6	Zen Hospice Project	Guest House Residence 272 Page Street Project based rental assistance program	3 project-based rental subsidies to persons infected with HIV/ AIDS	$51,764	$10,800 project-based rental assistance	Confirm no toxics; not in flood hazard area.	EXISTING
Total San Francisco County Uses:				*$558,780*	*$2,567,320*		

FUNDING REQUESTED

Sponsor	Type	# Beds	Capital	Rental	Services	Total
Baker Places/Bridge	New	25	$2,500,000		$179,128	$2,679,128
Baker Places	New	12		$50,364	$79,858	$130,222
Dolores Street	Existing	10	$167,500		$180,698	$348,198
Independent Housing	New	80		$300,000	$83,681	$383,681
Catholic Charities	Existing	32	$102,650			$102,650
Ark of Refuge	New	10		$15,000	$123,240	$138,240
Bernal Heights	New	6	$384,350			$384,350
AIDS Foundation	New	660		$303,364	$107,247	$410,611
Haight Ashbury Clinics	New	14	$1,050,000		$52,000	$1,102,000
Haight Ashbury Clinics	New	18	$1,347,500		$165,850	$1,513,350
Zen Hospice Project	Existing	3			$109,039	$109,039
HIP/Ambassador	Existing	15		$40,500	$107,900	$148,400
AIAI	New	10		$115,920	$77,442	$193,362
Larkin Street	New	20	$400,000			$400,000
Black Coalition Aids	N/A	14			$149,071	$149,071
Hospice by the Bay	Existing	51	$129,870		$65,542	$195,412
Maitri AIDS Hospice	Existing	8	$203,408		$133,519	$336,927
Totals Requested			$6,285,278	$825,148	$1,614,215	$8,724,641

FUNDING APPROVED July 9, 1993

Sponsor			Capital	Rental	Services	Total
Dolores Street	Existing	10	$50,000		$0	$50,000
Catholic Charities	Existing	32	$102,650			$102,650
Bernal Heights	New	6	$384,350			$384,350
Zen Hospice Project	Existing	3			$13,855	$13,855
Larkin Street	New	20	$400,000			$400,000
Hospice by the Bay	Existing	51	$129,870		$50,008	$179,878
Maitri AIDS Hospice	Existing	8	$203,408		$0	$203,408
Total Funding			$1,270,278		$63,863	$1,334,141

DEFERRED FUNDING DECISIONS

Sponsor			Capital	Rental	Services	Total
Baker Places	New	12		$50,364	$79,858	$130,222
Independent Housing	New	80		$300,000	$83,681	$383,681
AIDS Foundation	New	660		$303,364	$107,247	$410,611
HIP/Ambassador	Existing	15		$40,500	$107,900	$148,400
AIAI	New	10		$115,920	$77,442	$193,362
Haight Ashbury Clinics	New	10	$1,050,000		$52,000	$1,102,000
Black Coalition Aids	Existing	10			$149,071	$149,071
Total Deferred			$1,050,000	$810,148	$657,199	$2,517,347

APPLICATIONS NOT FUNDED

Sponsor			Capital	Rental	Services	Total
Haight Ashbury Clinics	New	18	$0		$0	$0
Ark of Refuge	Existing	10	$0		$0	$0
Baker Places/Bridge	New	25	$0		$0	$0
TOTALS						

otal Funding			$1,270,278	$0	$63,863	$1,334,141
otal Deferred			$1,050,000	$810,148	$657,199	$2,517,347
arget Amounts			$3,300,000	$1,450,000	$850,000	$5,600,000
emaining Balances			*$979,722*	*$639,852*	*$128,938*	*$1,748,512*

ATTACHMENT SEVEN

City and County of San Francisco

Department of Public Health

Date: October 11, 1993

To: HIV Health Services Planning Council

From: Bill Haskell

Subject: Recommendations for the use of CARE & HOPWA funds for HIV Housing Development plus Supportive Services and Operating Expenses

To support existing HIV housing programs and to facilitate the development of new HIV housing, the AIDS Office and Redevelopment Agency staff recommend the following for the use of CARE and HOPWA funds:

1. Continue to use both CARE and HOPWA funds to provide HIV housing programs. Leased housing should be supported with CARE funds, and owned housing should be supported with HOPWA funds.

2. Endorse the concept of multiple year funding for new HIV housing programs, depending on performance and the availability of funds, so providers of newly funded housing may be able to have some reasonable assurance of ongoing funding for supportive services and operating expenses.

3. Endorse the concept of switching the funding for ongoing supportive services and operating expenses, from HOPWA to CARE, after the first year of program operation for owned housing programs acquired with and initially supported by HOPWA funds.

4. Endorse the concept of facilitating HIV housing ownership and, in so doing, shifting housing programs from a model of leased housing funded by CARE to owned housing funded by HOPWA.

5. Continue to use both CARE and HOPWA funds to provide rental subsidy programs. This will ensure greater flexibility in maintaining the availability of subsidies.

Impact on CARE of Providing Multiple Year Funding for new CARE-supported housing programs in 94-95

To date, the impact of providing multiple year funding for new CARE-supported housing in 94-95 is significant: funding in the amount of **$522,500** would be provided to Catholic Charities of San Francisco (for the Shanti House contract which begins in November 93). This would be provided in response to the recent RFP which specifically stated that the amount available included the possibility of three 12 month renewals, depending on performance and the availability of funds.

AIDS OFFICE

25 VAN NESS AVENUE, SUITE 500
SAN FRANCISCO, CA 94102 - 6033

415 - 554-90
FAX 415 - 431-75

Impact on CARE of Switching Funding for Supportive Services & Operating Expenses for HOPWA-supported housing programs in 94 -95

To date, the impact of switching the source of funding (from HOPWA to CARE, after the first year of program operation) for supportive services & operating expenses in 94-95 is minimal: (1) funding in the amount of $50,008 to Hospice by the Bay (for Leland Avenue Residence) and (2) funding in the amount of $31,500 to Baker Places (for Ferguson House) would be switched from HOPWA to a CARE Supplemental cycle on July 1, 1994. The total impact is **$81,508**. However, it is important to be aware that this impact could increase in the future.

Background

With the advent of Housing Opportunities for Persons with AIDS (HOPWA) funds in 1992, San Francisco has had a source of funds which may be used for capital development for HIV-specific housing, either for acquisition and rehabilitation, or new construction. Prior to the availability of HOPWA as a funding source, the majority of the City's HIV-specific housing has been leased rather than owned, and supported primarily by CARE funds. In addition to capital development, HOPWA funds may also be used to fund lease/rental assistance programs, as well as any supportive services which may be linked to either of these types of housing programs.

San Francisco's 92 HOPWA award was $3,126,100. In establishing the priorities for the use of 92 HOPWA funds, the Planning Council targeted the following activities: $2.8 million (90%) for acquisition, rehabilitation and new construction; and $326,100 (10%) for lease/rental assistance. During this first year of HOPWA funding, the Council initially determined that HOPWA would fund housing but not supportive services, which were to be covered by CARE or other revenue sources. The reason for this decision was that HOPWA funds were limited and should support capital development for housing, which cannot be supported by CARE funds.

In October 1992, the Planning Council created a new non-competitive CARE service category for HOPWA-Specific Supportive Services. Later the same month, the Council expanded this new CARE service category to include the operating expenses of HOPWA-funded housing programs in 93, but determined that operating expenses should be moved to HOPWA in 94. However, after the Council established its priorities for the use of 93 CARE funds, it became appparent that CARE was oversubscribed. As a result, in December 1992, the Council reversed its earlier decision and determined that supportive services and operating expenses for all 93 HOPWA-funded housing programs would be funded by HOPWA, and not by CARE.

San Francisco's 93 HOPWA award was $5,600,000. In establishing the priorities for the use of 93 HOPWA funds, the Planning Council targeted the following activities: $3.3 million (59%) for acquisition, rehabilitation and new construction; $1.45 million (26%) for lease/rental assistance; and $850,000 (15%) for supportive services and operating expenses in HOPWA-funded housing. These percentages were based on the recommendations of the HIV Housing Network. They reflected a desire to both continue capital development, and to increase funding availability for lease/rental assistance so that more people could be helped on a short-term basis.

While all of the 92 and 93 HOPWA funds have not yet been allocated, one implication of using HOPWA to cover supportive services/operating expenses has become evident: whereas funding for capital development is a one-time expenditure, funding for supportive services/operating expenses is ongoing; **continuing to use HOPWA funding to finance supportive services/operating expenses will, over time, result in a reduction of the amount of funding available for new HIV housing development through capital (acquisition) programs.** The amount of funding available for capital development will continue to decrease annually as additional HOPWA funding is used for supportive services/operating expenses required for previously funded acquisition programs.

Strategies for the Use of CARE and HOPWA funds

No consistent policy has been established by the Planning Council concerning the use of CARE vs HOPWA funds in 1994, and future years, to finance the supportive services/operating expenses required for HOPWA-funded housing. To move toward such a policy, AIDS Office staff have been discussing with Redevelopment Agency staff the benefits of a strategy of switching the funding for supportive services/operating expenses for HOPWA-funded capital programs, from HOPWA to CARE, after the first year of program operation. Implementation of this strategy would: (1) enable new capital programs to have one primary source of funds (HOPWA) for development costs, start-up costs, supportive services and operating expenses during the start-up period; and (2) by switching (to CARE), remove the impact of the annual cost of supportive services/operating expenses on HOPWA funding intended primarily for capital development. Clearly, using CARE funds for supportive services/operating expenses is consistent with the purpose of CARE.

A separate strategy previously discussed by the Planning Council, and by AIDS Office and Redevelopment Agency staff, is that of facilitating the capability of HIV housing providers to move from the model of leased housing to the model of housing ownership. The intent of this strategy is two-fold: to further stabilize HIV housing programs for the long-term; and to enable CARE funding, which may be limited in the future, to be directed to support HIV services. Implementation of this strategy complements the earlier strategy because it would: (1) move housing providers from reliance on CARE funding for lease costs to HOPWA funding for acquisition and rehabilitation costs; and (2) remove the impact of the annual cost of lease expenses on CARE funding, intended primarily for HIV services. Clearly, using HOPWA funds for housing development expenses is consistent with the purpose of HOPWA.

Implications of Switching Supportive Services/Operating Expenses for HOPWA-funded Housing Programs, from HOPWA to CARE, and Providing Multiple Year Support

To date, 92 HOPWA funds have been awarded to only one capital program that included supportive services/operating expenses: Baker Places (for Fergeson Place) at $31,500 for supportive services. To date, 93 HOPWA funds have been awarded to only one capital program that included supportive services/operating expenses: Hospice by the Bay (for Leland Avenue Residence) at $50,008 for operating expenses.

Contracts for these supportive services/operating expenses have not yet been developed. However, it is anticipated that the source of funding for the services/expenses for the Hospice by the Bay housing program could be switched to a CARE Supplemental cycle on July 1, 1994. It is also anticipated that the services/expenses for the Baker Places housing program could be switched to a CARE Supplemental cycle on July 1, 1994. Accordingly, were this recommendation to be implemented, the current total impact on CARE funding would be **$81,508 per year.**

However, depending on the distribution of remaining 92 and 93 HOPWA funding, as well as the distribution of any future HOPWA funding, this impact could be substantially increased. Remaining unallocated 92 HOPWA funds amount to $1.5 million (which is included in the reissued Notice of Funding Availability for a dementia care residence). Remaining unallocated 93 HOPWA funds amount to $979,722 for capital development, $639,852 for rental assistance, and $128,938 for supportive services. These totals include deferred decisions in each category.

HOPWA regulations specify that: (1) program requirements, including income and affordability restrictions, shall remain in effect for 50 years; (2) persons with HIV disease must be served in housing developments for a minimum of 10 years; and (3) after 10 years, if there is no longer a need for HIV housing, and no funding is available for supportive services/operating expenses, the program may be altered to provide affordable housing for any persons who make less than 50% of the median income. Because of these regulations, agencies interested in developing HOPWA-supported housing programs will probably require some assurance regarding the availability of continuing support for services and operating expenses.

You may recall that Shanti Project had been awarded $1.5 million in 92 HOPWA funds for a moderate dementia care residence, which included $475,000 in supportive services/operating expenses. This program did not proceed due to the decision of the Shanti Board to discontinue the provision of housing services. Although this program will not be developed, it indicates the size of a supportive services/operating expenses budget which could be shifted to CARE on an annual basis.

In September 1993, the Redevelopment Agency went back out to bid to obtain proposals for the $1.5 million for a congregate residential facility for persons with moderate dementia, expanded to include persons requiring 24-hour care. Recent discussions with the two potential developers of this residential facility revealed that both are primarily concerned about the availability of ongoing funding for what may be substantial supportive services and operating expenses for this residential program. The interest of these agencies in pursuing the project will be dependent upon the potential for ongoing support for the supportive services and operating expenses.

Implications of Maintaining Supportive Services and Operating Expenses by Providing Multiple Year Support for new CARE-Funded Housing Programs

Ongoing support for the supportive services/operating expenses is an issue for new CARE-funded housing programs as well as HOPWA funded housing programs. To encourage interest in the service provider community in taking over the operation of Shanti House, the AIDS Office solicitation for this housing program supported by CARE funds included the possibility of three 12 month renewals, depending on performance and the availability of funds. For Catholic Charities, which will operate Shanti House, this amounts to **$522,500 per year** in CARE funds.

Implications of Facilitating HIV Housing Ownership and Shifting HIV Housing Programs from a model of Leased Housing funded by CARE to Acquired Housing funded by HOPWA.

The commitment to ownership of HIV housing (and to the exploration of acquiring this or a similar facility) was also required in the same AIDS Office solicitation for Shanti House. Therefore, while the CARE-funded contract with Catholic Charities will include the support of an annual lease, should this housing program ever be acquired with HOPWA funds it would no longer be dependent on CARE for the cost of its lease. This amounts to **$113,062 per year** in CARE funds which would no longer be required to support HIV housing that could be used to support other needed HIV services.

Should all other housing programs shift from leased to owned housing, the use of future CARE funds to support housing programs would be reduced. If the remaining CARE-funded housing programs which lease their residential facilities were to obtain HOPWA funds for acquisition, an additional **$253,742 per year** in CARE funds would be made available for HIV services.

Conclusion

The adoption of these recommendations is beneficial for the development and maintenance of all HIV housing programs in San Francisco because: (1) they enable the continuing support of existing HIV housing programs; (2) they ensure the ability to develop new HIV housing through capital programs; (3) they potentially reduce the reliance of leased HIV housing programs on CARE funding; and (4) they provide the possibility of ownership for non-profit HIV service organizations, securing HIV-specific housing for a minimum of 10 years.

IMPACT ON CARE	
I. MULTIPLE YEAR FUNDING FOR NEW CARE-SUPPORTED HOUSING	
94 - 95	95 - 96
- $522,500	- $522,500
	- other CARE - funded housing programs
II. SWITCHING FUNDING FOR SERVICES/EXPENSES FOR HOPWA-SUPPORTED HOUSING TO CARE	
94 - 95	95 - 96
- $81,508	- $81,508
	- Services/expenses for other HOPWA - funded housing programs
III. FACILITATING HOUSING OWNERSHIP AND SWITCHING HIV HOUSING TO HOPWA	
94 - 95	95 - 96
+ $113,062	+ $113,062
	+ Other CARE funds supporting leases available for HIV services

- = funding commitment that reduces CARE funds availableto support other services.

+ = funding commitment that increases CARE funds available to support other services.

WHAT DO THE CLIENTS SAY?

Assessing Client Experience with
HIV-Related Health and Supportive Services
in San Francisco

Presentation to:
Department of Public Health, AIDS Office and the
HIV Health Services Planning Council

October 11, 1993

Support Center Consulting Group
The Support Center for Nonprofit Management
70 10th Street, Suite 200, San Francisco, CA

ATTACHMENT NINE

"How does HIV affect your life?

What is your experience with the services in San Francisco?

This is a chance to tell your story...."

Goals of the project:

- To provide the HIV Health Services Planning Council and the AIDS Office with a clear picture of the experiences of the target population in San Francisco with the existing system of care.

- To articulate a "hierarchy of needs" for a client-focused system of HIV health services in San Francisco."

METHODOLOGY

Approach: Grounded Theory

Data Collection

- 22 Client Focus Groups, 194 Participants
- 2 Provider Focus Groups, 30 Participants
- Secondary Research

Data Analysis: Generation of Findings

Products

- Tapes and Transcripts of all Focus Groups
- Report of Findings

HIERARCHY OF NEEDS FOR A CLIENT-FOCUSED SYSTEM OF CARE

- To be treated with compassion and respect
- Reliable, comprehensive information about treatment and service options
- Streamlined access to a comprehensive system of services
- Help with needs that are not specifically HIV-related
- Systemic incentives which reward client health
- Outreach to those least motivated to improve their health
- The opportunity to contribute to the planning and delivery of service to others

Positive Experiences:

- The bottom line for many people is that they are getting the help they need.

- Clients deeply appreciate the efforts of many agency staff and providers.

  - Being seen as an individual, and getting a sense that the providers care about you is one of the most important aspects of positive experiences.

  - Relationships people have with individual agency staff and primary medical care providers are often excellent and are highly valued.

  - People know that agency staff are stretched, and have often received help that seemed to go beyond the call of duty.

Q-6

Positive Experiences:

- There are a lot of services if you can make it through the maze...

  - There is a clear perception that there are more and better services for HIV in San Francisco than anywhere else.

  - The array of services is seen to be extensive.

  - The only category of assistance that was repeatedly mentioned as particularly easy to access was food.

- A good relationship with a case manager, or someone playing that role, is seen to be the best way to fully utilize the help available.

Positive Experiences:

- The availability of culturally specific groups is appreciated by many.

- Clients value an element of choice in their decisions about HIV services and health care in general.

Negative Experiences:

- Problems in the interactions with service providers ...

  - HIV has a profound impact on people's lives, there is an oft expressed desire for more sensitivity throughout the focus group discussions.

  - Problems with confidentiality.

- Problems with information and decision making.

  - There is a significant amount of confusion about the best treatment route to follow.

  - There is a strong desire to inform the community at large in the hopes of developing more openess and effective prevention efforts, especially with youth and people of color.

Negative Experiences:

- Problems with access

  - Intake

  - Many respondents feel that services are delivered and awarded in a discriminatory fashion, based on the color of one's skin, one's gender or language ability.

  - The T-cell count as a rationing device to determine ellibility for services is seen to be used inconsistently, unfairly, and as a discouragement to getting better.

- Problems with availability of service

  - Unneccessary duplication is seen as a hindrance to providing all the help people are looking for.

  - Unmet needs.

Negative Experiences:

- Problems with lack of other basic services

  - The lack of basic other social services and support, including access to general primary care, creates additional dissatisfaction with the HIV-related services.

- Problems with lack of motivation to use services that are available

  - Need help right away, to help prevent lengthy denial period

  - Role of hopelessness and depression

Negative Experiences:

- Distrust of providing community

- Desire to be included in the planning and delivery of services

  - There is a desire for HIV+ people to be more involved in the delivery of care to others, there is a sense that there are few opportunities for this.

  - Desire to be involved with planning, to involve people with HIV.

9-12

F
22
1
10/18/93

DOCUMENTS DEPT.
OCT 18 1993
SAN FRANCISCO
PUBLIC LIBRARY

HIV HEALTH SERVICES PLANNING COUNCIL

October 18, 1993

25 Van Ness Ave., Third Floor Conference Room

4:00 to 8:00 p.m.

AGENDA:

I. Roll Call

II. Review of October 4th Meeting Minutes and Agenda

III. General Announcements
-- Determination of CARE Title II Representative

IV. Subcommittee Reports

V. Approval of CARE RFP Package
-- Funding Services for San Francisco Residents at Sites Outside County

VI. Review of CARE Applicant Eligibility Criteria

VII. Service Gaps & "Special Populations" Needs

VIII. Prioritization of New Funds; Continuation of Existing Programs

IX. Public Comment

SF
H22
#2
10/18/93

HIV HEALTH SERVICES PLANNING COUNCIL

October 18, 1993

25 Van Ness Avenue, Third Floor
4:00 - 10:30 p.m.

MINUTES

DOCUMENTS DEPT.
NOV 2 1993
SAN FRANCISCO
PUBLIC LIBRARY

MEMBERS

Present: Pat Christen, Marcy A. Fraser, Yvonne Frazier, Barbara Garcia, Estela Garcia, Jaime Geaga, Susan Karp, Gerald Lenoir, Steve Lew, James Loyce, Jr., Kent Macdonald, Scott Miller, J.B. Molaghan, Bob Nelson, Elliot S. Ramos, Steve Roger, Mike Shriver, Laura Thomas, Rita Times, Mary Jane Wood.

Absent: Lester D. Hanson, Gifford S. Leoung, Reggie Williams, Jerry Windley

Staff Present: Sophia Chang, Valerie Dorr, Bill Haskell, Judith Weld, Charles Brand.

I. Roll Call

Roll call was taken as above. The Members designated Mike Shriver to serve as temporary Chairperson. Accordingly, he did not vote on resolutions during the meeting.

II. Review of Minutes and Agenda

Paragraph II of the agenda for October 18 should read "October 11th Meeting Minutes. The minutes of October 11 and the corrected agenda of October 18 were accepted, with none opposed. Rita Times abstained.

III. General Announcements

Determination of CARE Title II Representative

Kent Macdonald announced that the Mayor's Office of Housing has completed their *Comprehensive Housing Affordability Strategy* report. There will be a 30-day public comment period before it is submitted to the Department of Housing and Urban Development.

•**CARE Title II Representative.** The Planning Council needs a San Francisco representative to the State of California Title II Working Group. The Working Group sets priorities for Title II funding, and the representative will have a vote on all policy matters. Any Member interested should contact Mike Shriver, who represented San Francisco last year.

•**Conflict of Interest.** Since Planning Council Members are concerned with both Title I and Title II, they are required to make the longer disclosure -- as are most City & County managers and professionals. After the Fair Political Practices Commission approves it, Members may complete and sign the proposed form.

•**Review of CARE Program Annual Reports.** A conflict of interest form was distributed to Members, to be completed during the session (Attachment Two). The form lists all CARE-funded agencies which will undergo annual report review. Members were asked to indicate if they had a conflict of interest, and to state the nature of that conflict. Members were advised to be conservative in completing the document. The AIDS Office will use the information to compose committees to review the annual reports of CARE-funded agencies.

IV. Subcommittee Reports

There were no subcommittee reports.

V. Approval of CARE RFP Package
Funding Services for San Francisco Residents at Sites Outside County

Judith Weld distributed the draft CARE RFP package, for consideration by the Members and explained the instructions and forms. Formerly the AIDS Office restricted each agency to one application per category. This requirement adversely affected agencies with different services, and the requirement was eliminated last year.

The following motion was made and seconded:

> **Each agency may submit only one application for each service, and whenever possible, only one application per service category.**

The motion passed unanimously, without opposition or abstention.

Ms. Weld asked whether an agency could combine several services solicited in various categories and submit one application under one service category. Bob Nelson was concerned that an agency might place its proposal in the wrong service category, and be eliminated in the review process on this technicality. Dr. Chang stressed that these problems will not occur if the Council carefully defines the services for which it is soliciting bids. The Planning Council, not the providers, had to drive the application process.

Marcy Fraser thought that the way the Council had arranged and defined the service categories on October 11, might lead to confusion, especially when a service was naturally dispersed into more than two categories (*e.g.*, Hospice and Home Health). Ms. Weld advised the members that when they began to discuss which new services to solicit, they would detect areas where service categories could be reorganized.

The Members discussed the proposal to require all bidders to have and document either one full year of experience providing the service in the relevant category to HIV/AIDS clients, or two years' experience delivering the service generally (*i.e.*, not specifically to HIV/AIDS persons).

The following motion was made, seconded, and carried unanimously, without opposition or abstention:

> **To require the following minimum qualifications of all agencies bidding for CARE-funded services: either one full year of experience providing that category of service to persons with HIV/AIDS; *or* two years' experience providing that category of service (but not specific to persons with HIV/AIDS).**

•**Funding Services to San Francisco Residents Outside San Francisco County.** Until now the policy has been not to fund such services, with the exception of some performed by Public Health agencies at the City & County prison facilities in San Bruno.

Q.- Could a provider located outside San Francisco provide services to non-San Francisco residents?
A.- Yes, so long as San Francisco CARE funds were used *only* to reimburse for services to San Francisco residents.

Pat Christen noted that this arrangement would be convenient for San Franciscan residents who worked in adjacent counties. Some members and staff expressed concern about the logistical evaluation and oversight problems this would create. The consensus was that the resulting logistical problems did not justify the "convenience." She made the following motion:

To allow the funding of services for San Francisco residents at agencies outside San Francisco, if comparable service was not otherwise available in San Francisco.

The motion passed unanimously, without opposition or abstention.

VI. Review of CARE Applicant Eligibility Criteria

Ms. Weld reviewed the new *Eligibility Form.* It permits reviewers to instantly disqualify bidders who are erroneously submitting proposals for prevention services, for services to non-residents, or who othrwise are ineligible. It also requires them to disclose whether their agency has been placed on probation by the AIDS Office. The Council instructed Ms. Weld to make modifications to sections 3, 4 and 5A.

The following motion was made and seconded:

To approve the Eligibility Form, as amended.

The motion was approved without abstention and with one Member, Kent Macdonald, opposed. Ms. Weld discussed the RFP section, "Review Criteria and Point Values", in the "Application Solicitation" part of the packet. In Section G ("Bidder Preference Points") the words "0 to 5" are to be changed to "0 or 5."

The following motions were made, seconded, and approved unanimously without opposition or abstention:

To approve the "Review Criteria and Point Value" section of the RFP, as amended.

To continue bidder preference points to people of color CBO's which apply.

Ms. Weld reviewed the "CARE Application Instructions" and Dr. Chang reviewed the rest of the package. Bob Nelson made the following motion, which was approved without opposition and with one abstention (Pat Christen):

To accept the entire RFP Package, as amended.

Ms. Weld announced that the AIDS Office was discussing with the Support Center the possibility of assisting bidders by reviewing their applications, especially the Eligibility Form. AIDS Office staff are not permitted, by City code, to look at bids until after the proposal deadline.

The Planning Council commended Ms. Weld for her work in preparing the RFP package.

VII. Service Gaps & "Special Populations" Needs

Sophia Chang distributed two data spreadsheets to assist Members in defining and prioritizing new CARE programs (see Attachment Three). Dr. Chang reviewed the information, noting how it would supplement and clarify the extensive needs assessment and service gap studies previously provided. The *Unmet Needs of HIV+ Population* spreadsheet reviews all of the service gaps identified in the needs assessment, Support Center focus groups, **People of Color and HIV/AIDS** report, CARE provider input, and the Planning Council's public hearing (see Attachment Two). The shaded box in the "Housing" category within the "Provider Input" column is derived from the Redevelopment Agency's **HIV/AIDS Housing Needs Assessment** (September, 1993), previously distributed to the Members. The last column, "Public Hearing," includes service gaps identified in written testimony submitted to the Planning Council by October 4. Although each group/ column has its own bias, there are large areas of correspondence which should assist Members in making decisions.

The second spreadsheet, *Review of current CARE-funded programs, by Service Category,* displays which services are now being provided, with notes on the number of clients served and various factors affecting the success of each program (see Attachment Four).

VIII. Prioritization of New Funds; Continuation of Existing Programs

Sophia Chang advised the Members that it must be specific regarding which new programs the Council wished bidders to bid on. The primary focus of Council activity during the evening would be to specify which services it wishes to include in each category, and identify them.

The Members reviewed service category modifications made at the October 11 meeting, including the transfer of hospice services *in the home* from the "Hospice" category to the "Home Health" category (see Attachment Five). The Members then divided into four groups, and each prepared a list of needed new programs. When the whole Council reconvened, the lists were coalesced (see Attachment One).

The following motions were made, seconded, and approved unanimously, without opposition or abstention:

To prioritize the use of new funds for these Primary Medical Care services and target populations: services for people of color; services at substance abuse treatment sites; integrated women's and children's services; services taken to homeless, substance users, and those at risk of homelessness.

To prioritize the use of new funds for these Housing services and target populations: long term subsidies for the general population (with or without money management services), including focused outreach to families, youth, people of color and active substance users; emergency vouchers for the general population and targeting families, active substance users and youth; Congregate

transitional Housing for youth, with Case Management services; Housing information and referral; One-time Housing assistance grants (including first and last months' rent, security deposits, moving expenses).

To prioritize the use of new funds for these Food Bank/ Home Delivered Meals services: general food services, culturally appropriate/ specialized food services (may include vouchers).

To prioritize the use of new funds for these Dental Care services and target population: dental services, including both preventive and restorative; and with a Spanish-language capability.

To prioritize the use of new funds for these Mental Health Therapy/ Counseling services and target populations: Long-term individual therapy, and short-term individual or group therapy, especially targeting youth, people of color, the homebound (including those in hospice), and transgender, transsexual, and transvestite persons. Ethno/ culturally specific models are encouraged; psychiatric assessments as support to other services, *e.g.*, Housing or Case Management; emphasis on the Spanish-speaking and multiply-diagnosed population; 24-hour crisis intervention with adequate psychiatric back-up; medication monitoring for psychiatric medications.

To prioritize the use of new funds for these Case Management services and target populations: Brokerage Case Management for youth, people of color, homeless, transgenders, transsexuals, transvestites, and substance users (applicants are encouraged to target clients early in the disease continuum and follow them throughout the course of their HIV infection; transitional services for the incarcerated; money management, with linkages to other services including, but not limited to, Housing.

To prioritize the use of new funds for these Substance Abuse Treatment/ Counseling services and target populations: residential treatment targeting people of color, women with children, gay men, and women (with sensitivity to Lesbians); and general sensitivity to sex workers; methadone maintenance; residential detoxification for clients addicted to heroin, speed and/ or crack (services should include special outreach to people of color); residential substance abuse treatment for the mentally ill.

To prioritize the use of new funds for these Home Health & Hospice Care services and target populations: Attendant care for those with and without skilled nursing needs, including services in emergency housing sites; Home Health services, including Hospice care in clients' homes.

To prioritize the use of new funds for these Client Advocacy services and target populations: benefits counseling and legal services, with outreach to people of color communities (applicants are encouraged to link services to Case Management); print or electronic media outreach to people of color regarding the availability of HIV services, with particular attention to the Latino community; simplified service delivery directory or other reference tool which is designed for

clients (not providers); treatment information and advocacy that is targeted to people of color and those with low literacy.

To prioritize the use of new funds for this Direct Emergency Assistance service: vouchers to cover utilities, clothing, and other critical personal needs.

To prioritize the use of new funds for increasing the availability of Alternative/ Complementary/ or Conventional Therapy services.

To prioritize the use of new funds for these Buddy/Companion services and target populations: peer model emotional and practical support, both one-to-one and in groups, targeting youth and children (HIV+ or HIV-), clean and sober, heterosexuals, and people of color (including monolingual Spanish-speakers).

To prioritize the use of new funds for this Residential Hospice Care service: enhanced residential hospice.

To prioritize the use of new funds for these Rehabilitation Care services: assistive or adaptive educational and rehabilitative devices and services (including low vision services).

To prioritize the use of new funds for these Day & Respite Care services: aAdult day health; child care, including emergency and respite care.

To prioritize the use of new funds for these Transportation servics, for transportation to medical care and to meet critical personal needs: general transportation vouchers, including taxi vouchers and bus tokens; all applicants are encouraged to provide linkage to Medical Care and Case Management:

To prioritize the use of new funds for Translation/Interpretation services (including ASL) linked to Case Management, Medical Care, and/or Client Advocacy.

To prioritize the use of new funds for this Adoption/ Foster Care Assistance service: child placement assistance, with Spanish-language capability.

Kent Macdonald made the following motion, which was seconded:

To combine residential Hospice and Home Health, under the Home Health category.

The motion did not pass.

The Members discussed how to utilize the estimated $15 million in new CARE funds. It was agreed *not* to simply distribute it proportionally among the eighteen services, according to their current share. Each service category was discussed and a percentage of *total* CARE funds assigned to it, which included anticipated new revenue. The new distribution is the following:

Distribution of CARE Funds

Service Category	Total CARE Funds (FY 1993)	Total to CBO's (1993)	Percent of Total CBO Amount (1993)	1994 DISTRIBUTION of Total CBO Amount
Primary Medical Care	$5,570,781	$1,689,343	9.7%	7%
Housing	$2,030,773	$2,030,773	11.7%	15%.
Food	$ 888,551	$ 888,551	5.1%	5%
Dental	$ 505,607	$ 505,607	2.9%	5.5%
Mental Health	$2,357,575	$1,313,984	7.5%	7.5%
Case Management	$1,326,323	$ 938,879	5.4%	5.5%
Substance Abuse	$4,468,652	$3,367,655	19.3%	19%
Home Health*	$1,579,627	$1,579,627	9.1%	10%
Client Advocacy	$ 976,395	$ 976,395	5.6%	6%
Dir. Emergency Assist.	$ 547,414	$ 547,414	3.1%	2%
Alternative Care	$ 498,477	$ 498,477	2.9%	3%
Buddy/Companion	$ 937,066	$ 937,066	5.4%	4%
Hospice*	$ 565,741	$ 565,741	3.2%	4%
Rehabilitation	$ 805,440	$ 805,440	4.6%	1%
Day/Respite	$ 349,316	$ 349,316	2.0%	3%
Transportation	$ 81,026	$ 40,042	0.2%	0.5%
Translation	$ 27,301	$ 27,301	0.2%	0.5%
Adoption	$ 108,110	$ 108,110	0.6%	0.5%
Other	$1,250,328	$ 255,802	1.5%	1%
TOTAL	$24,875,503	$17,426,523		

•Continuation of Existing Programs
Mary Jane Wood made the following motion, which was seconded:

To refund all existing CARE Title I (Formula and Supplemental) and Title II projects, if they passed the appropriate evaluations and reviews.

The motion passed with 6 in favor, none opposed, and the following abstentions: Pat Christen, Barbara Garcia, Gerald Lenoir, Steve Lew, Scott Miller and Elliot Ramos.

The following motion was made and seconded:

To include a 4.5% Cost of Living Adjustment [COLA] in all refunded projects.

The motion passed with 6 in favor, none opposed, and the following abstentions: Pat Christen, Barbara Garcia, Gerald Lenoir, Steve Lew, Scott Miller and Elliot Ramos.

IX. Public Comment

There was no public comment.

ATTACHMENTS:

(1) *New Funding Priorities Adopted by the Planning Council October 18, 1993.* See next page.
(2) *Conflict of Interest* form, 2 pages.
(3) Health Services Branch [HSB], *Review of current CARE-funded programs, by Service Category.*
(4) HSB, *Unmet Needs of HIV+ Population.*
(5) HSB, *HIV-Related Service Categories (in Planning Council Service Priority Order)*, 10/15/93.

NEXT PLANNING COUNCIL MEETINGS:
November 8th and 22nd: 4:30-7:30 p.m.

o/wp/brand:/pcl1018.doc 10/25/93 15:07

Attachment One

NEW FUNDING PRIORITIES

Adopted by the Planning Council on October 18, 1993

Primary Medical Care

*Services for *people of color.*
*Services taken to *homeless*, *substance users,* and *those at risk of homelessness.*
*Services at substance abuse detox sites.
*Integrated *women's* and *children's* services.

Housing & Housing Related Services

*Long term subsidies for the general population (with or without money management services), including focused outreach to *families, youth, POC,* and *active substance users.*
*Emergency vouchers for the general population and targeting *families*, *active substance users* and *youth.*
*Congregate transitional Housing for *youth*, with Case Management.
*Housing information and referral.
*One-time Housing assistance grants (*e.g.,* first and last months' rent, security deposits, moving expenses).

Food Bank/ Home Delivered Meals

*General food services.
*Culturally appropriate/ specialized food services (May include vouchers).

Dental Care

*Dental services, including both preventive and restorative, and with *Spanish-language* capability.

Mental Health Therapy/ Counseling

*Long-term individual therapy, and short-term individual and group therapy, especially targeting *youth, people of color, the homebound* (including those in *hospice*); *transgender, transsexual,* and *transvestite* persons. Ethno/ culturally specific models are encouraged..
*Psychiatric assessments as support to other services, *e.g.,* Housing or Case Management. Emphasis on the *Spanish-speaking* and *multiply diagnosed* populations..
*24-hour crisis intervention with adequate psychiatric back-up.
*Medication monitoring for psychiatric medications.

Case Management

*Transitional services for the *incarcerated.*
*Money management, with linkages to other services including, but not limited to, Housing.
*Brokerage Case Management for *homeless, substance users, youth, people of color, transgenders, transsexuals, and transvestites.* Applicants are encouraged to target clients early in the disease continuum and follow them throughout the course of their HIV infection.

Substance Abuse Treatment/ Counseling

*Residential treatment targeting *people of color, women with children, youth, gay men,* and *women* (with sensitivity to *lesbians*); and general sensitivity to *sex workers.*
*Methadone maintenance.

Substance Abuse Treatment/ Counseling (Cont.)

*Residential detoxification for clients addicted to heroin, speed, and/or crack. Services should include special outreach to *people of color.*

*Residential substance abuse treatment for *mentally ill.*

*All substance abuse services are encouraged to link and cooperate with needle exchange services.

Home Health & Hospice Care

*Attendant care for those with and without skilled nursing needs; including services in emergency housing sites.

*Home Health services, including Hospice care in clients' home.

Client Advocacy

*Benefits counseling and legal services, with outreach to people of color communities.

*Print or electronic media outreach to *people of color,* with particular attention to *Latino* community, regarding the availability of HIV services.

*Simplified service delivery directory or other reference tool which is designed for clients (not providers).

*Treatment information and advocacy that is targeted to *people of color* and those with *low literacy.*

*Applicants are encouraged to link and cooperate with Case Management services.

Direct Emergency Assistance

*Vouchers to cover utilities, clothing, and critical personal needs.

Alternative/ Complementary/ or Conventional Therapy

*Services.

Buddy/Companion Services

*Peer model emotional and practical support, both one-to-one and in groups, targeting *youth, children* (HIV infected and HIV affected), *clean and sober* individuals, *heterosexuals,* and *people of color* (including *monolingual Spanish speakers*).

Residential Hospice Care

*Residential Hospice services (more beds).

Rehabilitation Care

*Assistive, adaptive, educational/ rehabilitative devices and services (including vision services).

Day & Respite Care

*Adult day health.

*Child care, including emergency and respite care.

Transportation

*General transportation vouchers, including taxi vouchers, bus tokens, for transport to medical care and to meet critical personal needs.

*Applicants are encouraged to link to Medical Care and Case Management.

Translation/Interpretation

*Translation/ interpretation services (including ASL) linked to Case Management, Medical Care, and/or Client Advocacy.

Adoption/ Foster Care

*Child placement assistance, with *Spanish-language* capability.

ATTACHMENT TWO

CONFLICT OF INTEREST IN THE REVIEW OF CONTRACTOR'S PROGRAM REPORTS

A Planning Council member would have a conflict of interest in serving on a team to review the annual Program Reports for any CARE-funded renewal program if any of the following apply: **(1)** you are currently a Board member, employee, or paid consultant to the organization; **(2)** you have ever been a Board member, employee, or paid consultant to the organization. (However, any employment of less than six months duration more than five years ago may not necessarily be a conflict of interest.); **(3)** you have any plans to seek employment, consulting work, or Board membership with the organization; **(4)** you have any other working relationship (unpaid consulting, advisory committee or coalition membership, program involvement of any kind, nomination of board members) which you feel might hinder your ability to objectively review the Program Report for the organization's renewal program; or **(5)** you have a personal relationship with a Board member or employee of the organization which others might perceive to constitute a conflict of interest.

If any of these situations apply to you in relationship to any of the contractors on the attached list whose Program Reports are to be reviewed, please place a check noting conflict of interest in the appropriate column **and** state the nature of the conflict. This information will be used to establish Program Report review teams for Council members so that conflict of interest is avoided.

2.2

Please Print Your Name Here

Agency	Exhibit	☑If Conflicted	State Nature of Conflict(s)
AIDS Emergency Fund	Emergency Housing Payments Emergency Housing		
AIDS Benefits Counselors	Eligibility Counseling		
AIDS Indigent Direct	Case Management Client Services		
AIDS Indigent Direct	Case Management		
AIDS Indigent Direct	Mental Hlth/SA Services Client Services		
AIDS Legal Referral Panel	Legal Services		
American Indian AIDS Inst.	Case ManagementPractl. Emot.Support		
American Indian AIDS Inst.	Case Management		
Baker Places, Inc.	Trans.Res. Rx-MH (New Place)		
Bayview Hunter's Point	The Cadre-Emot. Support Team		
Bridge for Kids	Respite Child Care		
Catholic Charities	Rita DaCascia Support		
Catholic Charities	Residential Attendant Care		
Coming Home Support	Money Management		
Continuum HIV Day	Adult Day Health		
Continuum HIV Day	Substance Abuse Counseling		
Family Service Agency	Mental Health Services		
Filipino Task Force on AIDS	Translation Services		
GAPA Community HIV Project	Case Management		
GAPA Community HIV Project	Case Management		
GMOC/EACH	Community Evente Ind Treatment Adv.		
Home Care Companions, Inc.	Home Care Skills Training		
Instituto Familiar de la Raza	Psychosocial SupportPsychotherapy Services		
Larkin St.Youth Center	Youth Center		
Maitri AIDS Hospice	Residential Hospice		
National Task Force on AIDS	Brothers Support Services		
Operation Concern	Psychosocial Support Services		
Operation Concern	Outpatient Mental Health		
Project Open Hand	AIDS Food Bank Meal Service		
Project Open Hand	Delivered Meals AIDS Food Bank		
Project Open Hand	Food Bank Hot Meale Service		
St. Mary's Hospital HIV Svcs.	AIDS Dementia Unit		
St. Mary's Hospital HIV Svce	Outpatient HIV Care		
S.F. AIDS Foundation	Emergency Housing VouchersEmergency Housing		
S.F. AIDS Foundation	Women's Case Management		

2-3

Agency	Exhibit	☑If Conflicted	State Nature of Conflict(s)
S.F. Community Clinic Consortium	Primary Medical Care		
SFDPH-CMHS	Mental Health CM Acute Psych.Services		
SFDPH-CPHS	Primary Care Services Case Management SPY-Primary Care SPY Case Management TB Control Division/Lab		
SFDPH - CSAS	Substance Abuse Treatment		
SFDPH - Forensics	Early Intervention		
SFDSS	Family Services		
SFDPH - SFGH	Early Intervention ClinicWard 86, AIDS Clinic Psych.Consult/Liaison HIV-IDU Case Management Minority AIDS Care		
S.F. Food Bank	HIV Emergency Food Boxes Food Solicitation		
S.F. Suicide Prevention	Night-Time Ph Crisis Hotline		
Support Center	Technical Assistance		
Tenderloin AIDS Network	Emotional Support Svcs		
UCSF/AIDS Health Project	Psychiatric Consult Svcs.Mntl Hlth Comm. Liaison Ward 86/Mental Health Svcs.		
UCSF/AIDS Health Project	Volunteer Therapy Women's Svcs./ASAP		
UCSF/AIDS Health Project	Gen. Pop./ASAP Youth Svcs./ASAP Psy. Consult Svcs		
UCSF/Center on Deafness	Psychosocial Services		
UCSF/Center on Deafness	MentalHealth Services		
Walden House, Inc.	Long Term Residen.Drug Rx		
Walden House, Inc.	Long Term Residen Treatment		
Westside Community Mental Hlth	Attendant Care		
18th St. Services	O/P Subst. Abuse Couns.		
University of the Pacific	Dental Care		
Visiting Nurses & Hospice	Residential Site Care/ShantiAIDS Hospice Care/CHH		
Visiting Nurses & Hospice	In-Home Respite Care Home Health Care/Ambassador		

Review of current CARE-funded programs, by Service Category

Service Type	Current CARE Programs (*Notes new 93-94 prog)	Description	Number Served	Utilization Notes from FY 1992-93
Primary Medical Care	• DPH* • SFGH • Forensics • CmtyClinics • Private hospital •Desig.Women's Clinics	• General, with TB & youth • General, with Ward 86 & 93 • Early Intervention • Early Intervention • General • Women's Care	• 1245 • 1175 • 525 • 832 • 170 • 273	Overall met 77% of target No evidence of less utilization by women or persons of color *Availability of reimbursement, Title IIIb*
Housing	• Emergency vouchers • Transitional Subsidies* • Transitional Congregate • Long-term Subsidies* • Long-term Congregate • Long-term Non-Congreg	• General • Youth • General, Afr Am • General, Family (Youth soon) • General, Youth • General	• 1736 • 50 • 95 • 277 • 144 • 68	Overall met 166% of target Less than expected utilization by Latinos, APIs *Availability of HOPWA $*
Food/ Delivered Meals	• CBO Providers (2) one food bank only other food bank/meals	• Food Bank • Home-Delivered Meals • Liquid Supplements*	• 964 • 612 • (NA)	Met 150% of target Less than expected utilization by Latinos/Asians
Dental Care	• One Dental School provider	Preventive and interventional care	• 1158	Met 192% of target Less than expected utilization by POC
Mental Health	• DPH/CMS • MH Services at SFGH (provided by UCSF) • MH Services at HC #1* • CBO providers • Private Hospital	• Acute psych/MH case mgmnt • Psych consult/MH liaison/svcs on Ward 86/volunteer therapists • Multi-diagnosis program • Therapy and Crisis Intervention (incl youth, NA, Latinos, deaf) • Crisis Intervention	• 277 • 1534 • 50 • 580 • 60	Met 75% of target Less than expected utilization by Latinos/Asians *Current cuts in local/State funding for MH services*

Service Type	Current CARE Programs (*Notes new 93-94 prog)	Description	Number Served	Utilization Notes from FY 1992-93
Case Management	• CPHS (incl youth) • CBO* • CBO* • Money Management	•Medical CM • Medical CM • General (incl NA, Asian, Latino, women, Tenderloin res) • General	•600 •365 • 754 • 129	Met 86% of target More than expected by POC (except Asians)
Subst Abuse Tx	• Residential treatment* • Outpatient treatment • Multidiagnosed Detox* • Outpatient detox* • Counseling • Methadone	•muticult incl Af Am men,women • incl associated with resid prog • SFGH/DPH inpatient + resid • SFGH + CBO • incl women/youth • SFGH-based	• 399 • 240 • 500 • 100 • 630 • ??	Met 116% of target Less than expected utilization by Latinos *?Other federal funds coming to SF for SA Tx*
Home Health	• Attendant Care • Attendant Care* • Home Infusion	• General and assoc with CM • Linked to residential sites (including Tenderloin hotels) • by CBO for SFGH patients	• 146 • 199 • 78	Met 142% of target Utilization as expected by race/ethnicity *Availability of reimbursement (usually for more ill patients)*

Service Type	Current CARE Programs (*Notes new 93-94 prog)	Description	Number Served	Utilization Notes from FY 1992-93
Client Advocacy	• Benefits Counseling • Legal Services • Outreach • Treatment/Trials Info • Hotline	• General • General & immigration • People of color communities • POC and Latinos • General and POC	•120 • 537 • 754 • 265 • 5450	Met 104% of target (does not include outreach) Less than expected utilization by Latinos, A/PIs (not incl outreach)
Dir Emerg Asst	• CBO	• Housing vouchers only	• 1159	Met 158% of target Less utilization by Latinos
Alternative Care	• 3 CBOs*	• General & targeting Afr Ams	• 350	No data (new category)
Buddy/ Companion	• General (2 CBOs) • POC pop-spec(3 CBOs) • Training • Other Special Pop*	• Tenderloin & Mission districts (incl volunteer recruitment) •Am Ind, Afr Am • Caregivers • Deaf, youth	• 720 • 182 • 250 • 35 (NOT incl youth #s)	Met 83% of target Less than expected utilization by Latinos/APIs *Does NOT include City $ (Psychosocial RFP)*
Hospice	• 24-hour care • Residential hospice	• at designated sites • single site	• 55 • 50	Met 102% of target Utilization as expected
Rehab	• Dementia Care • HIV/MH Care • Low Vision*	• subacute hospital site • single residential site • (two CBOs)	• 42 • 15 • 105	Met 94% of target Less use by Latinos/APIs

3.4

Service Type	Current CARE Programs (*Notes new 93-94 prog)	Description	Number Served	Utilization Notes from FY 1992-93
Day/Respite	• Childcare* • Adult Day Health • In-home Respite	• in-home and summer camp • single CBO site • home care services	• 43 • 125 • 30	Met 149% of target No significant deviance from expected utilization *Note past experience with underutilization of respite*
Transportation	• DPH* • One CBO	• for patient use • for general use	• 450 • 150	Met 101% of target Utilization as expected
Translation/ Interpretation	• Single CBO program*	• Tagalog only	•25	New category/no data
Adoption/ Foster Care	• DSS	•	• 35	Met 120% of target Less than expected util by Latinos
Other	• Primary provision of technical assistance*	• Workshops & intensives		

UNMET NEEDS OF HIV+ POPULATION

Service Category	Client Survey *(10/4/1993)*	*People of Color and HIV/AIDS (1992)*	Provider Input *(September 1993)*	Public Hearing *(9-27-93)*
Primary Medical Care	• *Afr Ams* • *Latinos* • *Mixed Race/ Ethnicity* • *Persons with higher CD4 counts*	• *Women* • Perinatal care for *NA* women [*Afr Ams* in clinical trials] [*A/PIs* in clinical trials]	• MDs in Bayview • Urgent Care • Timely access to medications (incl. delivery) [Clinical trials for monolinguals]	• Medical care for *Children* in clinical trials • More locations • Home visits • More extensive coverage • Dental procedures •At SA TX sites
Housing	• *Youth*	• *Afr Am*, esp *women* with *children; youth, active users,&* those on methadone • *Family* units (A/PIs) • *Latinos*	• Long-term, clean/sober • Affordable • Financial assistance with move-in costs • Safe neighborhood • Help in finding [viz Notes]	• *Families* • *Latino*-sensitive • Reasonable (Asian male) • More affordable housing & timely access • Aid with rent increases
Food/Delivered Meals	• *Afr Ams* • *Heterosexuals*	• Culturally appropriate *(A/PI)* • Vouchers	• Culturally approp *(A/PI)* • Meeting total caloric needs	• General need
Dental Care			• General need	
Mental Health	• *Afr Ams* • *Youth*	• Therapy/counseling *(A/PI)* • Mental health services and crisis intervention *(NA)*	• *Transexuals/transvestites* • *Gay/lesbian Latino* • Therapy for *homebound/hosp* • Biling./cult-sens counseling • 24-hr. emergency services • Psych medicines monitoring • Therapists of color • HIV inpatient treatment beds • Psychotherapy (incl. long-term) • Neuropsych/cognitive assessmts	• *Youth* • Counseling in hospice • Rapid access to individual counseling & therapy • Longer-term individual counseling

4-2

Service Category	Client Survey (Unmet Need)	POC Report	Provider Input	Public Hearing
Case Management	• *Transgender* • *Youth*	• *Youth* • *A/PIs* • *Homeless IDUs* • Transitional services from jails • Interagency CM	• *Incarcerated* • Medical case management • Cult/ling sensitive services • Financial mgt. & rep. payee • Coordination between hospital & community services	• Help to access services • Transitional services from jails
Substance Abuse Services	• *Latinos* (outpatient) • *Youth*	• *A/PIs* • *Latinos* • *NA* (incl alcohol day program) • *NA* Residential drug and alcohol detox programs	• *Youth* • *women, lesbians* • *Latinos, Spanish monolingual* • *gay men* • Residential Tx for *A/PI* • Separate *gay/lesbian* grps • Treatment beds for *mentally ill* • Treatment beds • Methadone slots for HIV+ • Methadone slots for *women* • Drug/alcohol Tx • Long-term & acute med detox • Low cost therapy for abusers (Tx to mainstream) • Residential methadone detox?	• *Latino*-sensitive residential treatment
Home Health	• *Uninsured* • *IDUs*		• Attendant care • Attendant training • Attendant care for persons without skilled nursing needs	• Home care

4-3

Service Category	Client Survey (Unmet Need)	POC Report	Provider Input	Public Hearing
Client Advocacy		• *Afr Am*, esp *gay/bisexual* • Effective outreach to: *Afr Am,s A/PIs*, esp. *transgenders Latinos, NAs* • Need for legal services and advocacy services *(A/PI)* • Legal services for *immigrants*	• Outreach to: *women families Latinos* • Info about med resources • Info about cult sensitive svcs • Translated info (Tagalog) • Literacy sens info on alt care • Services without photo ID • POA for health care • One-on-one benefits counseling • Conservatorship	• Benefits counseling • Financial counseling/help for *asymptomatics* • Peer advocacy
Direct Emergency Assistance			• More emergency assistance • Clothing & food • For visiting families	• Financial support • Clothing
Alternative Care		• Access to holistic and trad med	• Care to inpatients • Free and low-cost care	• Alternative care (incl tradtl Chinese med) • Rapid access • Longer-term treatment
Buddy/ Companion	• *IDUs* • *Heterosexuals*	• *Family members* • *African Americans* • *Latino transgender* • *NA* support groups & peer educ • Spiritual support (grief & bereavement)	• Support for: *children of HIV+ parents, partners/ survivors, out-of-town family, heterosexual couples/ singles, monolingual Spanish women* • Practical support volunteers • Groups for clean & sober	• Support for *Latinos/as* • Counseling/support for *children*
Hospice		• *Latino* facility	• Resources to remain in home during terminal phase of illness	
Rehab			• Emergency adaptative equipment	• Assistive devices

4-4

Service Category	Client Survey (Unmet Need)	POC Report	Provider Input	Public Hearing
Day/Respite	• *IDUs*		• More adult day health • Crisis nursery • Summer programs for children • Childcare for SA Tx clients	• Emergency child care (for hospitalized parent)
Transportation		• *Native Americans*	• Accessible/low cost • Wheelchair accessible	• *Women* • *children*
Translation/ Interpretation			• Translation for *transgenders* • Deaf interpretation services	
Adoption/ Foster Care			• Temporary guardianship • Assistance to families for placement of children	
Other		• Interagency collaboration • Help with operational expenses • Increase provider salaries • Forums for service providers • Technical support to agencies • Art and cultural education		• Better coordination between agencies • Non-clinical technical assistance to agencies • Insensitivity of service providers

ATTACHMENT PW2

HIV-RELATED SERVICE CATEGORIES
(in Planning Council Service Priority Order)

1. **Primary Medical Care:** Provision of routine, non-emergency, non-inpatient, non-specialized medical care.

2. **Housing and Housing-Related services:** This includes: emergency housing vouchers, assistance in locating and obtaining suitable, on-going or transitional shelter (including costs associated with finding a residence and/or subsidized rent); and, residential housing services, which are the provision of housing assistance in a group home setting.

3. **Food bank/Home Delivered Meals:** Provision of actual food or meals to clients.

4. **Dental Care:** Diagnostic and therapeutic services rendered by dentists, dental hygienists, and similar professional practitioners.

5. **Mental Health Therapy/Counseling:** Psychological and psychiatric treatment and counseling services, including individual and group counseling, provided by a mental health professional licensed or authorized within the State, including psychiatrists, psychologists, clinical nurse specialists, social workers, and counselors.

6. **Case Management:** Client-centered service that links clients with health care and psychosocial services in a manner that ensures timely, coordinated access to medically appropriate levels of care and support services, and continuity of care. Key activities include: assessment of the client's needs and personal support systems; development of a comprehensive, individualized service plan; coordination of the services required to implement the plan; client monitoring to assess the efficacy of the plan; and periodic re-evaluation and adaptation of the plan as necessary over the life of the client. Services providing money management and representative payee services are considered a form of case management.

7. **Substance Abuse Treatment/Counseling:** Provision of treatment and/or counseling to address substance abuse (including alcohol) problems. Services may be provided in a residential or oupatient setting and include detoxification programs.

8. **Home Health and Hospice Care:** Therapeutic, nursing, supportive and/or compensatory health services provided by a licensed/certified home health agency in a home/residential setting in accordance with a written, individualized plan of care established by a case management team that includes appropriate health care professionals. Component services may include:
   Para-Professional Care: homemaker, home health aide, and personal/attendant care
   Professional Care: routine and skilled nursing, rehabilitation and mental health
   Specialized Care: intravenous and aerosolized medication treatments, diagnostic testing, parenteral feedings and other high tech services
   Hospice Care: nursing care, counseling, physician services, and palliative therapeutics provided by a hospice program to patients in their home setting.

9. **Client Advocacy:** Assistance provided to individuals with respect to wills, funeral arrangements, matters related to protection of civil rights, and other relevant needs experienced by clients. Advocacy services include information and outreach services (including telephone hotline services) targeted to populations or persons with HIV infection.

10. **Direct Emergency Assistance:** Provision of short-term payments for utilities, medications or other resources. CARE funds may not be used to provide direct financial assistance (i.e., money) to individual clients.

11. **Alternative/Complementary/or Conventional Therapy:** Includes traditional chinese medicine, vitamin therapy, and non-pharmacologic adjuncts to standard Western treament of HIV disease (e.g., acupuncture).

12. **Buddy/Companion Services:** Activities provided by volunteers/peers to assist the client in performing household or personal tasks, and providing mental and social support to combat the negative effects of loneliness and isolation. These services include peer model support groups and the training of non-professional caregivers.

13. **Hospice care:** Residential hospice care services, including facility and staffing support (meeting State licensure requirements).

14. **Rehabilitation Care:** Services provided by a licensed or authorized professional in accordance with an individualized plan of care which is intended to improve or maintain a client's quality of life and optimal capacity for self-care. This definition includes dementia care, physical therapy, speech pathology, low-vision training services, and payment for assistive and rehabilitative devices within a plan of care.

15. **Day and respite care:** Residential or home-based non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of client or client's child. This service includes adult day health programs with on-site medical care services and general child care outside of clients' homes.

16. **Transportation:** Conveyance services provided to a client in order to access health care or psycho-social support services. May be provided routinely or on an emergency basis.

17. **Translation/Interpretation:** Services to facilitate communication between the client and service provider. May include one-on-one or telephone translation/TDD services.

18. **Adoption/Foster Care Assistance:** Assistance in placing children whose age is less that 20 because their parents are unable to care for them due to HIV-related illness or death, in temporary (foster care) or permanent (adoption) homes.

HIV HEALTH SERVICES PLANNING COUNCIL

October 25, 1993

25 Van Ness Ave., Third Floor Conference Room

4:30 to 7:30 p.m.

AGENDA:

DOCUMENTS DEPT.
OCT 2 0 1993
SAN FRANCISCO
PUBLIC LIBRARY

I. Roll Call

II. Review of October 18th Meeting Minutes and Agenda

III. General Announcements

IV. Brief Presentations on AIDS Office Women's Surveys

V. Subcommittee Reports

VI. Designation of CARE Title II Representative

VII. Plan for the Transition from RFP Recommendations to Grant Application Budget

VIII. Review Calendar of Upcoming Events/ Work Plan

IX. HOPWA -- Planning and Policy-Setting

X. Discussion of Department of Public Health CARE Allocations

XI. Discussion of Marin and San Mateo County CARE Allocations

XII. Annual Report Review Process

XIII. Plan for Grant Expenditure Review

XIV. Public Comment

NOVEMBER MEETINGS

November 8 November 22

25 Van Ness Avenue, Third Floor, 4:30PM -- 7:30PM

o/wp/brand/pcagend. (P 6)

SF
H22
#2
10/5/93

SF

HIV HEALTH SERVICES PLANNING COUNCIL

October 25, 1993

25 Van Ness Avenue, Third Floor
4:30 - 7:30 p.m.

MINUTES

DOCUMENTS DEPT.
NOV 2 1993
SAN FRANCISCO
PUBLIC LIBRARY

MEMBERS

Present: Marcy A. Fraser, Yvonne Frazier, Barbara Garcia, Estela Garcia, Lester D. Hanson, Susan Karp, Steve Lew, James Loyce, Jr., Bob Nelson, Steve Roger, Laura Thomas, Jerry Windley, Mary Jane Wood.

Absent: Pat Christen, Jaime Geaga, Gerald Lenoir, Gifford S. Leoung, Kent Macdonald, Scott Miller, J.B. Molaghan, Elliot S. Ramos, Mike Shriver, Rita Times, Reggie Williams.

Staff Present: Sophia Chang, Valerie Dorr, Bill Haskell, Judith Weld, Charles Brand.

I. Roll Call

Roll call was taken as above. The Members designated Estela Garcia to serve as temporary Chairperson. Accordingly, she did not vote on resolutions during the meeting.

II. Review of Minutes and Agenda

The minutes of October 18 were corrected as follows: The last sentence on Page 7 should read: "The motiion passed with 5 in favor,none opposed, and the following abstentions: Pat Christen, Barbara Garcia, Gerald Lenoir, Steve Lew, Scott Miller, *Bob Nelson*, and Elliot Ramos." (Bob Nelson was among those who abstained in the vote on the motion to include a 4.5% COLA in all refunded projects.) The corrected minutes of October 18 and the agenda of October 25 were accepted unanimously, with none opposed or abstaining.

III. General Announcements

Bob Nelson reported on a recent effort to fold HOPWA into other programs of the Department of Housing and Urban Development. The strong response secured from HUD officials a verbal comittment to save HOPWA. Mr.Nelson asked Members to be on the lookout for a potential action alert, should additional advocacy be required.

IV. Brief Presentations on AIDS Office Women's Surveys

Delia Garcia and Dr. George Lemp discussed AIDS Office studies released on October 19. They show that lesbian and bisexual women are at high risk for HIV infection (see Attachment One). Three years ago, the AIDS Office Surveillance Section asked the Centers for Disease Control to fund a study to test the assumption that lesbians were not a group at high risk for HIV infection. The project is the most exhaustive seroprevalence study on this subject to date, and demonstrate that sexual identity group behavior cannot be behaviorally stereotyped.

V. Subcommittee Reports

There were no subcommittee reports.

VI. Designation of CARE Title II Representative

James Loyce discussed the functions and responsibilities of the CARE Title II representative. Barbara Garcia volunteered to assume this position.

The following motion was made, seconded, and passed unanimously, without opposition or abstention:

> **That HIV Health Services Planning Council member Barbara Garcia shall represent San Francisco on the HIV Comprehensive Care Working Group, as its Title II representative.**

VII. Plan for the Transition from RFP Recommendations to Grant Application Budget

Dr. Sophia Chang listed the deadlines that the Planning Council must meet in November, December and January. They must review 86 annual reports, participate in RFP review panels, and approve a final CARE grant application budget. The Council agreed on a calendar (see end of minutes).

To facilitate the review of proposals, the following grouped service categories were proposed:

(1) Primary Medical	*Dental*	*Rehabilitation*
(2) Home Health	*Hospice*	*RespiteAdoption*
(3) Housing	*Food*	*Direct Emergency Assistance*
(4) Case Management	*Transportation*	*Client Advocacy Translation*
(5) Mental Health	*Buddy/Companion*	
(6) Substance Abuse	*Alternative Care*	

These combinations are for the review teams purposes only. CBOs will be encouraged to combine their various service components under the *primary* service category, rather than segregate each into a separate program. For example, a CBO that proposes to provide medical clinical services with some associated transportation services, should propose a single program within the Primary Medical Care category. Members were referred to *New Funding Priorities* (Attachment One of the Minutes of October 18) for guidance.

The Council discussed possible approaches to minimizing the splitting of programs between Supplemental and Formula funds, resulting in double reporting and different contract time periods. The problem belies simple analysis, and should be considered by every Member.

VIII. Review Calendar of Upcoming Events/ Work Plan

See the calendar agreed on by the Council (see end of minutes).

IX. HOPWA -- Planning and Policy-Setting

Bill Haskell and Deborah Drickersen-Cortez discussed HOPWA and their relationship to CARE funds to support services as well as capital development for new HIV housing.

Mr. Haskell reviewed the earlier memorandum to the Planning Council, dated October 11, 1993, concerning recommendations for the use of CARE and HOWA funds for HIV housing development plus supportive services and operating expenses. He stated that the five

strategies included in this memo provided a comprehensive picture of how the AIDS Office and Redevelopment Agency staff desire to use these two funding sources most effectively to develop new HIV housing. Mr. Haskell noted that the Council had already endorsed the concept of multiple year funding for new housing programs, so that housing providers could have some reasonable assurance of ongoing funding for supportive services and operating expenses. This was accomplished on July 26, 1993, when the Council adopted a motion to set aside CARE Title I funding in the range of up to a dollar-for-dollar match of HOPWA capital funding, for a period of up to five years.

Mr. Haskell and Ms. Drickersen-Cortez requested that the Council endorse one additional strategy which would complement the entire motion, which is to: (1) start new capital developments entirely with HOPWA funds (for acquisition, rehabilitation, start-up, *and* supportive services and operating expenses) for the initial contract period; and (2) switch the ongoing support for the services and operating expenses to CARE after the first year of program operation. Should the Council endorse this strategy, these supportive services and operating expenses would be picked up by CARE at the next possible CARE funding cycle. Given a favorable performance and the availability of federal CARE funds, these supportive services and operating expenses would then be funded by CARE on an annual basis.

All decisions regarding HOPWA funds are made by the Redevelopment Agency Loan Committee, which includes Agency executive director, the Homeless Coordinator, the director of the Mayor's Office of Housing as well as the AIDS Office staff representative (Bill Haskell) and two Planning Council members (Marcy Fraser and Rita Times).

A concern was raised about how supportive services and operating expenses would be monitored. Mr. Haskell stated that this would be done by the AIDS Office. The Redevelopment Agency has no background in supportive services, and recognizes the competence of the AIDS Office to administer this component of housing programs. Accordingly, it will fund a staff position that will deal specifically with this area. The person in this position will be located at the AIDS Office and trained by its staff, so that all contracts for supportive services and operating expenses in HOPWA-funded housing programs are developed and monitored in a similar manner.

Mr. Haskell asked the Planning Council to formally consider the third recommendation he made in his memorandum of October 11 (see Attachment Seven of the Minutes of October 11, 1993). The proposal reflects the Council's resolution on July 26, 1993 regarding the use of CARE funds to support HOPWA-funded housing projects.

The following motion was made, seconded, and approved unanimously, with Bob Nelson and Lester D. Hanson abstaining:

> **To switch the funding for ongoing supportive services and operating expenses from HOPWA to CARE, after the first year of program operation for owned housing programs acquired with and initially supported by HOPWA funds; providing that (1) CARE funds are available and (2) the program has been favorably evaluated by the Planning Council.**

X. Discussion of Department of Public Health CARE Allocations

Dr. Sophia Chang led a discussion of the Health Department's share of next year's CARE funds. Currently DPH receives just under 30% of CARE funds (excluding the allocations for Administration and the counties of Marin and San Mateo). If next year's funding is $28,400,000, DPH at the same level would receive $7,450,000. Subtracting the cost of CARE-funded AIDS Office staff, the DPH total is actually around 28%. The Council requested information on the amount of unexpended funds within the current DPH CARE budget. Program surpluses are usually designated for non-AIDS Drug Assistance Program (ADP) drugs, particularly psychotropic medications and other HIV drugs not covered by ADP.

Currently the Departmental AIDS Committee is in the process of prioritizing proposals for new or augmented programs and will submit their recommendation to Executive Staff in December.

The following motion was made and seconded:

> To maintain a thirty percent (30%) ceiling for CARE funds allocated to the Department of Public Health. The maximum amount of new funds shall not exceed $6,000.000

Steve Roger amended the motion, as follows:

> **To maintain a thirty percent (30%) target ceiling for CARE funds allocated to the Department of Public Health. The maximum amount of new funds shall not exceed $6,000.000.**

The motion passed unanimously, with none opposed and Yvonne Frazier abstaining.

XI. Discussion of Marin and San Mateo County CARE Allocations

Members received the March 31, 1993 AIDS statistics for the three counties of the EMA (see Attachment Two). Dr. Chang reported that Marin and San Mateo currently receive approximately 12% of CARE funds (around $1,550,000). If the Council bases next year's allocation on the percentage of living persons with AIDS in each county of the EMA (total 5,119) on March 31, 1993, Marin will receive 7.2% and San Mateo 6.9%: a total of 14.1%, which translates to $2,700,000 of a projected $19,300,000 in CARE Formula funds.

The Members-nominee of Marin and San Mateo were asked how they felt about this breakdown. Geoffrey Sackett said that he was satisfied. A. Gene Copello found the Formula figure acceptable, but inquired how the Council divided the CARE Supplemental funds. Marin has received some Supplemental funds in the past. Dr. Chang responded that the Council encouraged Marin and San Mateo Counties to apply for Supplemental funds, and could proceed with discussing their respective allocations when they submitted their proposals for CARE Formula and Supplemental funds. Mr. Sackett and Dr. Copello will present their proposals to the Council on November 8.

The following motion was made, seconded, and passed unanimously, with Mary Jane Wood abstaining:

> **To allocate CARE Formula funds to Marin and San Mateo Counties according to their percentage of the total number of persons living with AIDS in the San Francisco EMA on March 31, 1993.**

XII. Annual Report Review Process

Bill Haskell presented the procedure for the Council's review of the the annual reports submitted by the CBOs. It is based on the recommendation of the Monitoring Subcommittee, which the Planning Council adopted on September 13.

There will be twelve teams, with two Members on each, as well as Fiscal and Health Services Branch staff. The sessions will begin promptly at 4:00 p.m. and four teams will meet on each of the following days: November 12, 15 and 29. They will review a total of 86 annual reports. (Of the total of 145 programs, 30 were new programs and only submitted checklists; and 29 renewed programs received site visits). Mr.Haskell distributed some team packages, including an evaluation checklist (see Attachment Three).

The result of the review will be one of four courses of action: (1) No action required; (2) No "red flags," but an informal visit initiated; (3) Some "red flags," necessitating a modified monitoring and site visit; (4) Many "red flags," dictating a comprehensive site visit.

XIII. Plan for Grant Expenditure Review

See sections XI and XII, *supra.*

XIV. Public Comment

There was no public comment.

ATTACHMENTS:

(1) Department of Public Health, *Two New Surveys show that Lesbians and Bisexual Women are at High Risk for HIV Infection*, **AIDS News and Information** (DPH press release on 10/19/93); and DPH AIDS Office Surveillance Branch, **HIV Seroprevalence and Risk Behaviors among Lesbians and Bisexual Women: The 1993 San Francisco/ Berkeley Women's Survey,** 10/19/93. The press release is attached. Both studies are available from the AIDS Office, Surveillance Section.
(2) Health Services Branch, *Persons with AIDS -- March 31, 1993.*
(3) Health Services Branch, *Contractor Annual Program Report Review Teams: "Red Flag" Checklist.*

PLANNING COUNCIL CALENDAR

Date	*Event*
November 8	Planning Council meeting (4:30 p.m.)
November 12	Annual Reports review (by teams)
November 15	Annual Reports review (by teams)
November 22	Planning Council meeting (4:30 p.m.)
November 29	Annual Reports review (by teams)
December 2	☞Mandatory training for RFP review teams
December 13	Planning Council meeting (4:30 p.m.)
December 14	RFP review teams meet*
December 15	RFP review teams meet*
December 16	RFP review teams meet*
December 17	RFP review teams meet*
December 20	RFP review teams meet*
December 21	RFP review teams meet*
January 3	Planning Council meeting (4:30 p.m.)
January 10	Planning Council meeting (4:30 p.m.)
January 24	Planning Council meeting (4:30 p.m.)

*Each Council member will have one of these days.

☞We anticipate returning to the normal schedule of Planning Council meetings (second and fourth Mondays each month) in February 1994.

o/wp/brand:/pcl1025.doc 10/29/93 14:11

ATTACHMENT ONE

EMBARGOED UNTIL:
TUESDAY
OCTOBER 19, 1993

AIDS

CONTACT: WENDY IWATA
(415) 554-2556

NEWS AND INFORMATION

City and County of San Francisco Department of Public Health

TWO NEW SURVEYS SHOW THAT LESBIANS AND BISEXUAL WOMEN ARE AT HIGH RISK FOR HIV INFECTION (COMMUNITY PRESENTATION OF SURVEY RESULTS ON TUE., 10/19/93, 10 AM)

Lesbians and bisexual women report substantial levels of unsafe sexual and drug-using behaviors with male and female partners that may put them at high risk for HIV infection, according to two separate studies released today by the San Francisco Department of Public Health.

One of the two studies, entitled "HIV Seroprevalence and Risk Behaviors among Lesbians and Bisexual Women: The San Francisco/Berkeley Women's Survey", surveyed 498 lesbians and bisexual women 17 years of age and older who were randomly sampled at 25 locations (including bars, dance clubs, cafes, street locations and special events) in San Francisco and Berkeley, CA during 1993. The study found that 1.2% were infected with HIV, 5.4% had markers for hepatitis B, and 0.4% had markers indicating a history of syphilis. The prevalence of HIV infection did not differ significantly by age, race/ethnicity, or sexual orientation. The prevalence of HIV infection in this population was more than three-fold higher than that estimated for all adult or adolescent women in San Francisco (0.35%; based on household and street-based surveys, surveys of childbearing women, clinic-based surveys, and screening of blood donors and military recruits). Lesbians and bisexual women in this survey reported very high levels of injection drug use and unsafe sexual behaviors with male and female partners. A substantial proportion of women reported injection drug use since 1978 (10.4%), and 3.8% reported injecting drugs in the past three years. Among those reporting a history of injection drug use since 1978, 71% reported a history of sharing needles, and 31% reported sharing needles with gay/bisexual men. Among the 405 women who reported a history of sex with men, many reported unprotected oral (56.3%) vaginal (39%) or anal (10.9%) sex with men during the past three years. Of particular concern, these women reported a high rate of unprotected oral, vaginal, or anal sex with gay/bisexual men (14.6%, 9.6%, 3.2%, respectively) or with male injection drug users (6.4%, 5.2%, 1.7%, respectively) during the past three years. In addition, among those reporting a history of sex with women, 91.9% reported a history of unprotected oral sex, 28.8% reported unprotected sharing of "sex toys" and 25.2% reported unprotected vaginal fisting during the past three years.

The study found no clear evidence of woman-to-woman transmission among the six HIV-infected women. All of these women reported either a history of injection drug use or a history of anal or vaginal sex with men. Despite the lack of clear evidence of woman-to-woman transmission in this survey, the high rates of injection drug use and unsafe sexual

behaviors with male and female partners suggests a potential for continued transmission of HIV in this population.

The San Francisco/Berkeley Women's Survey was conducted by a team from the Surveillance Branch of the Department's AIDS Office led by Dr. George Lemp, Melissa Jones, Tim Kellogg, and Giuliano Nieri, in collaboration with researchers from the Berkeley Department of Health and Human Services and the Division of HIV/AIDS, Centers for Disease Control and Prevention.

The second of the two studies, entitled "Health Behaviors among Lesbian and Bisexual Women: Results from a Community-Based Survey", mirrored and supported many of the results in the first study. This survey of 483 lesbians and bisexual women recruited from various community locations in San Francisco investigated health service utilization, disease histories, a variety of health behaviors, and exposure to HIV prevention programs and messages. In terms of health service utilization, the study found that women's clinics and emergency rooms were the most frequently used providers (44% and 41%).

Similar to the HIV seroprevalence survey, the study found high rates of unsafe sexual behavior among self-identified lesbians and bisexual women. Fourty-seven percent of lesbians and 58% of bisexual women reported not always using a condom when having sex with men. Seventy-four percent of lesbians reported sex with only women in the past three years, 22% with both women and men, 3% with only men, and 1% reported no sexual activity. Among bisexual women, 72% reported sex with women and men in the past three years, 12% with only men, 12% with only women, and 4% reported no sexual activity.

The San Francisco Women's Health Survey was conducted by a team from the Prevention Services Branch of the Department's AIDS Office led by Stephen Mills, Delia Garcia, Ruben, and Tia Martinez.

Previous studies released by the Department of Public Health have shown that focused prevention campaigns have been very successful in San Francisco when targeted to populations at high risk through comprehensive community-based prevention efforts. Although the rates of HIV infection among lesbian and bisexual women are currently low, these rates may rise given the high levels of risk behaviors in this population. These studies suggest that targeted prevention programs should be expanded to address the needs of lesbians and bisexual women.

A full presentation of the results of these two surveys will be held on Tuesday, October 19, 1993 from 10:00 to Noon at the New Conservatory Theatre, 25 Van Ness Avenue, Basement Level.

Copies of the two reports are available from the Surveillance Branch or the Prevention Branch of the AIDS Office, SFDPH, 25 Van Ness Ave., Suite 500, San Francisco, CA 94102. Phone: (415) 554-9050 (Contact: Susan Black) or (415) 554-9040 (Contact: Judith Sedgwick).

For Press calls, contact: George Lemp, Dr.P.H. (554-9050), Stephen Mills (554-9040), Mitchell Katz, M.D. (554-9010), or Wendy Iwata (554-2556).

ATTACHMENT TWO

PERSONS WITH AIDS – March 31, 1993

Marin - San Francisco - San Mateo

	Marin	*San Francisco*	*San Mateo*
CASES	721	13,713	953
DEATHS	351	9,315	602
ALIVE	*370*	*4,398*	*351*
*%/Total:**	*7.2%*	*85.9%*	*6.9%*

**Percentage of 3-County Total (5,119).*

Marin: *7.2279%*
S Fran.: *85.9152%*
S Mateo: *6.8568%*

ybn101493

ATTACHMENT THREE

Contractor Annual Program Report Review Teams
"Red Flag" Checklist

The following are issues to keep in mind as you review the contractor annual program reports:

Programmatic:

a. Excessive staff turnover
b. UOS/UDC provision below 70%
c. No demonstration of resolution, or significant progress, in meeting prior monitoring report recommendations.
d. Significant number of client grievances
e. Issues raised by contractor which do not seem to be satisfactorily resolved.
f. Lack of description of appropriate linkages, or lack of documentation of such linkages
g. Achievement of process and/or outcome objectives below 50%
h. Significant changes in client population which differs from the target population specified in the contract.
I. Incomplete invoice information

Administrative and Fiscal:

a. Audit report is delayed more than 3 months after original due date to the AIDS Office.
b. Audit report not conducted in compliance with A-133
c. Repeated failure to resolve fiscal and administrative issues identified in last monitoring report.

This agency information may be provided to review teams as part of a response to a fiscal and administrative protocol, as well as the audit report and any other supplemental material available.

d. Non-compliance with the 70% rule.

HIV HEALTH SERVICES PLANNING COUNCIL

November 8, 1993

25 Van Ness Ave., Third Floor Conference Room

4:30 to 7:30 p.m.

AGENDA:

I. Roll Call

II. Review of October 25th Meeting Minutes and Agenda

III. General Announcements

IV. Subcommittee Reports
Report on Health Outreach Team Evaluation

V. Proposal for Emergency Funds to Maintain Continuum

VI. Marin and San Mateo Counties CARE Proposals

VII. Process for Designating Community Co-Chair

IX. Public Comment

DOCUMENTS DEPT.
NOV 2 1993
SAN FRANCISCO
PUBLIC LIBRARY

NOVEMBER MEETINGS

November 22

25 Van Ness Avenue, Third Floor, 4:30PM -- 7:30PM

o/wp/brand/pcagend. (P 7)

DOCUMENTS DEPT.
NOV 1 3 1993
SAN FRANCISCO
PUBLIC LIBRARY

HIV HEALTH SERVICES PLANNING COUNCIL

November 8, 1993
25 Van Ness Avenue, Third Floor
4:30 - 7:30 p.m.

MEMBERS

Present: Pat Christen, Marcy A. Fraser, Yvonne Frazier, Barbara Garcia, Estela Garcia, Jaime Geaga, Lester D. Hanson, Susan Karp, Gerald Lenoir, James Loyce, Kent Macdonald, Jr., Scott Miller, J.B. Molaghan, Bob Nelson, Elliot S. Ramos, Steve Roger, Laura Thomas, Rita Times, Jerry Windley, Mary Jane Wood.

Absent: Gifford S. Leoung, Steve Lew, Mike Shriver, Reggie Williams.

Staff Present: Mitch Katz, Sophia Chang, Joseph Cecere, Bill Haskell, Cynthia Selmar, Charles Brand.

I. Roll Call

Roll call was taken as above. The Members designated Estela Garcia to serve as temporary Chairperson. Accordingly, she did not vote on resolutions during the meeting.

II. Review of Minutes and Agenda

The following corrections were made to the minutes of the meeting of October 25: Judith Weld did not attend that meeting; Michelle Dixon did attend; in section X., the correct amount of CARE funds is $6,000,000 (six million); in section XII, the correct dates of the review process are November **1,** 15 and 29. The minutes of October 18 and October 25 and the Agenda of November 8 were accepted, with three Members abstaining.

III. General Announcements

- Bill Haskell discussed the second program review session, to be held on November 15. Team members received lists and packets of review materials.
- Eric P. Goosby, MD, of HRSA, informed the Council that the President signed the 1994 Title I appropriation. The FY 1994 supplemental Title I grant application must be submitted by January 14, 1994 (see Attachment One).
- Yvonne Frazier has resigned from the Council, effective November 16, 1993 (see Attachment Two).

IV. Subcommittee Reports

Report on Health Outreach Team Evaluation

Dr. Mitchell Katz, Director of the AIDS Office, discussed the investigation of the Health Outreach Team (hereafter **HOT**), and reviewed the AIDS Office *Special Investigation Report*; his October 22, 1993, notification to Ms. Frances Strauss, Acting President of the HOT Board of Directors; and his November 1, 1993, memorandum to the Members of the Planning Council (available upon request). Dr. Katz made a

similar presentation at the hearing of the Planning Council Subcommittee on the Evaluation of HOT (available upon request). At 3:00 p.m. on the 8th, the Subcommittee heard and reviewed information provided by the AIDS Office and HOT, and voted to accept the recommendations of the AIDS Office. The AIDS Office cannot rely on HOT to provide medical care, or further support its unsafe practices. The Council should determine an alternative for to providing these services. Subcommittee member Yvonne Frazier reviewed the procedures of the hearing.

Elliot S. Ramos made the following motion:

A) **That the Planning Council accept the recommendations of the AIDS Office and the Subcommittee on the Evaluation of HOT, regarding the Health Outreach Team.**

Member Kent Macdonald noted that the public should have an opportunity to testify before a vote was taken. Co-chairperson James Loyce, Jr., announced that each person would have two minutes to testify.

Geoffrey Froner said that the proceedings were an attempt to smear and defund HOT. The AIDS Office had violated its own procedures. There was never any exit interview, and its final report had just been sent out. Its activity certainly did not serve the needs of a difficult population. Had the Council Members read the response of the HOT Board of Directors? The charges were based on review of only 19 of HOT's 200+ patient charts. Half of these were of HIV- persons. The AIDS Office criticized HOT's staffing situation, but ignored the difficulty of finding staff that were effective with HOT's clients, and that HOT has had an effective staff since May 1993. Mr. Froner asked the Council to consider the "procedural wrongness" of the process.

Gerald Lenoir inquired about clinic licensure and the prescription of medications without physician's approval. Mr. Froner responded that since 1991, HOT had received CARE funds for its case management and *outreach* medical services. It was never HOT's intention to be a clinic. In 1991 and 1992 the AIDS Office commended HOT's medical services. No mention was made of clinic licensure, although they were told about numerous other license, reporting, and protocol requirements. Why did AIDS Office staff continue to sign HOT contracts?

Laurens White, MD, testified that many physicians sign blank prescriptions for nurse practitioners. HOT nurse practitioners *renewed* prescriptions for drugs that had been prescribed by SFGH, although these might not have been in the formulary.

J.B. Molaghan observed that since HOT performed outreach medical services in dangerous places, that was another reason not to have blank prescriptions. There were also other medication violations against patient welfare. Mr. Froner responded that no blank prescription was ever misused.

Rita Times asked about HOT's destruction of documentation upon which it based its billings. Mr. Froner responded that the "documentation" was paper logs at the office manager's desk. As soon as she typed them into the computer, she discarded them.

This was explained carefully to the investigative team, and has been HOT's procedure for three years. Joseph Cecere of the team confirmed that HOT was not retaining the original documents, and there was no source to check when the team uncovered inconsistencies in the billings and patient records.

Kent Macdonald asked if the original probation issues were corrected. Dr. Katz responded that at that time he was not aware of many of the radical problems at HOT. These were uncovered in the process of following up on the original charges. Mr. Froner observed that the AIDS Office was effectively putting HOT out of business, even though the persons cited were no longer employed there.

Robert Surber, Ph.D., deputy chief of Community Services at the SFGH Department of Psychiatry, testified. HOT was a brilliant conception. Their case management thinking was right on target for this population. Their "paper" was a mess, and he has consulted them on this matter. Geoffrey Froner responded bureaucratically -- effectively. He found 95% compliance with case management standards -- not the 50% deficiency cited by the AIDS Office. The AIDS Office is dead wrong, and this leads him to question the rest of the report. Why couldn't they find a middle ground? No other group will be able to provide their services.

Dr. Anselm Strauss, a board member of HOT, testified. He did field work here ten years ago, and met Geoffrey Froner seven years ago. Why did the AIDS Office fund him if he had no medical experience -- and knowing all their experience. The AIDS Office and the Subcommittee were *also on trial.* The two reports are poles apart on medical items. There has been no communication back on forth. What the AIDS Office criticizes is probably going on all over.

John Dean Green, a member of the public, said he was incredulous that Dr. White admitted to signing blank prescriptions. If this had occurred in Marin County, he would turn the matter over to the District Attorney's office. How can he be trusted to write protocols?

Cynthia Selmar, a member of the investigative team, noted that she reviewed the same 19 charts that Dr. Katz did. They lacked case management headings. There were unsigned and undated notes. This was illegal and unprofessional conduct.

Gerald Lenoir asked why the team chose "19" charts. Dr. Katz noted that most problems encountered were with the charts of HIV+ persons. Charts of HIV- persons' were okay. If he had reviewed more HIV+ charts, the situation would have become worse. Initially they randomly chose 12 charts: clients whose names began with the letters "B", "M" and "W". Subsequently, he went through 40 other charts to find notes by a physician's assistant. In the process of doing this, he incidentally noted serious matters that demanded follow-up. Mr. Froner said that *12* charts were chosen randomly, and seven were selected. Half of the charts were of HIV- persons, many of whom were seen only once or twice. The team put the *worst* perspective on everything, and distorted facts to back up their negative conclusions.

Kent Macdonald said that he respected Dr. Katz' interpretations and conclusions. However, the Planning Council had made it clear that it wanted HOT to succeed. The AIDS Office investigation was to be problem-solving. HOT seems to be correcting old problems, but the team appears to be prosecutorial. He was concerned about HOT clients, and urged the Members to vote against the motion.

Pat Christen said that Members must vote in favor of the motion, for their clients' sake. The patients are in danger. The HOT board found it acceptable to write blank prescriptions. The quality of their oversight evidently cannot change. The AIDS Office cannot constantly oversee HOT operations.

A motion to end discussion was approved unanimously. The motion passed, with Kent Macdonald opposed and three Members abstaining (Jaime Geaga, Gifford Leoung and Jerry Windley).

Mary Jane Wood noted that the HOT response (Page 6), states that she had said that there seemed to be a conspiracy. Ms. Wood wished to clarify her statement. She had said that she *understood* their belief that there was a conspiracy.

Dr. Katz asked Planning Council members to assist him in diverting funds to new providers. A new Council subcommittee was formed, consisting of J. B. Molaghan, Elliot Ramos, Marcy Fraser and Jaime Geaga.

Mr. Froner inquired how long HOT would be able to operate. Mr. Loyce responded that HOT would soon receive written communication providing details of the termination process.

V. Proposal for Emergency Funds to Maintain Continuum

Dr. Katz proposed that the Council provide emergency funds to Continuum to allow it to continue its adult day health care programs until July 1, 1994. The agency's programmatic focus was uniquely successful. Continuum had not requested these funds, but rather procedurally informed the AIDS Office that its funds were running out and they were suspending operations. The Medi-Cal reimbursement procedures do not facilitate their billings, and the resulting deficits were crushing the agency. Their board of directors succeeded in obtaining an $85,000 settlement from Medi-Cal, and their promise to be more responsive to Continuum's T.A.R.s. They had also searched for a collaborative relationship with different hospitals, but promising negotiations with California Pacific Medical Center were frustrated by the hospital's financial crisis. Continuum is planning to reduce its administrative office space in another tactic to reduce its deficit.

If the Council provides $200,000, which was available from salary savings and other surpluses as of October 1, Continuum can operate until June 30, 1994. The agency will apply under the competitive RFP process for adequate funding beginning July 1, 1994.

Mary Jane Wood, who is familiar with Continuum, asked several questions regarding its enrollment of new clients and attendant billing procedures. Yvonne Frazier noted

that the Council should adopt procedures for dealing with this unique situation. Two clients testified about the significance of Continuum in their lives.

Jerry Windley made the following motion, which was seconded:

> To provide $200,000 emergency funding to Continuum, to enable it to continue its operations through June 30, 1994; said funds to derive from unexpended funds in other programs.

Gerald Lenoir amended the motion to read:

B) **To provide $200,000 emergency funding to Continuum, to enable it to continue its operations through June 30, 1994; said funds to derive from unexpended funds in other programs. Such funding shall be subject to continuing financial review by the AIDS Office.**

The motion carried with none opposing and Mary Jane Wood abstaining.

VI. Marin and San Mateo Counties CARE Proposals

John Dean Green, acting Director of the Marin County AIDS Office, presented the county's CARE supplemental request for $243,000. Mary Jane Wood presented San Mateo's proposals, on behalf of AIDS Program Director A. Gene Copello, MD.. They reviewed their handouts (see Attachment Three).

Bill Haskell noted that historically Marin and San Mateo Counties received *Formula* funds based on their proportion of persons with AIDS of the total EMA population. Dr. Sophia Chang recommended listing each county's request *by service category* and following San Francisco's request, in each category.

Rita Times asked the opinion of the Marin and San Mateo representatives. Geoffrey Sackett, of the Marin AIDS Council, and Ms. Wood agreed with this approach.

Laura Thomas made this motion, which was seconded:

C) **To accept San Mateo's and Marin's proposals for CARE Supplemental funds, and the AIDS Office recommendation to divide their requests into the service categories and list each separately, following San Francisco's.**

The motion carried, with none opposed and three abstaining (Pat Christen, Mary Jane Wood and Bob Nelson).

VII. Process for Designating Community Co-Chair

Charles Brand distributed a letter from co-chair Reggie Williams indicating his resignation from the co-chair position and his nomination of Estela Garcia to succeed him (see Attachment Four). J.B. Molaghan and Jerry Windley supported Ms. Garcia, who announced that the Mayor had originally asked her to assume the position, but that she had delayed until she had a sense of the wishes of the Council.

Jerry Windley and Laura Thomas said that in the future, the Council should be careful to designate an HIV+ representative as co-chair. Pat Christen suggested designating a third co-chair to immediately achieve this -- although Mr. Loyce and Ms. Garcia would serve the Council's business needs well. Gerald Lenoir agreed with this proposal; and endorsed Ms. Garcia, who had taken on many subcommittee assignments and displayed true leadership.

Estela Garcia expressed her appreciation of the unanimous endorsement by the Members. She was equally confident in them. She too had considered the need for an alternate co-chair, and asked Member Mike Shriver if he would accept this role. Mr. Shriver agreed, and she will convey this information to the Mayor.

Pat Christen objected to the word "alternate", as implying a diminished role.

J.B. Molaghan made this motion, which was seconded and approved unanimously:

D) **To approve the appointment of Estela Garcia and Mike Shriver as co-chairpersons, to serve with James Loyce, Jr. upon their appointment by the Mayor.**

The following motion was seconded and passed unanimously:

E) **To express the appreciation of the HIV Health Services PlanningCouncil for the dedicated and successful leadership of Reggie Williams as co-chairperson, and to wish him every success in his new endeavors.**

VIII. Public Comment. There was no additional public comment.

ATTACHMENTS:

(1)Eric P. Goosby, MD, to All Title I Chairpersons and Title I Planning Councils (fax), 11/3/93.
(2)Yvonne Frazier to James Loyce, 11/3/93.
(3)[Marin County] *Supplemental Request; San Mateo County AIDS Program Ryan White CARE Titles I and II Current and Suggested Funding.*
(4)Reggie Williams to Sophia Chang, MD; 11/1/93.

PLANNING COUNCIL CALENDAR

Date	*Event*
November 22	Planning Council meeting (4:30 p.m.)
November 29	Annual Reports review (by teams)
December 2	Mandatory training for RFP review teams
December 13	Planning Council meeting (4:30 p.m.)
December 14-17	RFP review teams meet*
December 20-21	RFP review teams meet*
January 3	Planning Council meeting (4:30 p.m.)
January 10	Planning Council meeting (4:30 p.m.
January 24	Planning Council meeting (4?30 p.m.)

*Each Council member will be assigned one of these days.

o/wp/brand:/pcl1025.doc 11/16/93 13:18

ATTACHMENT ONE

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Bureau of Health Resources Development

Health Resources and Services Administration
Rockville MD 20857

FAX TRANSMISSION COVER SHEET

DATE: November 3, 1993

TO: All Title I Chairpersons and Title I Planning Councils

FROM: HRSA/BHRD/DHS Eric P. Goosby, M.D.

Division of HIV Services (DHS)

Bureau of Health Resources Development (BHRD)

Health Resources and Services Administration (HRSA)

This document consists of 2 pages, including this cover page. Should you have any problems with this transmission, please call the Division of HIV Services at: 301-443-6745. The FAX number for the Division of HIV Services is: 301-443-5271.

Comments:

1-2

C.A.R.E.fax

BUREAU OF HEALTH RESOURCES DEVELOPMENT • DIVISION OF HIV SERVICES • TEL 301-443-6745 • FAX 301-443-8371

FY 1994 APPLICATION GUIDANCE INFORMATION FOR TITLE I GRANTEES

The President signed the FY 1994 appropriation bill for the Ryan White CARE Act on October 21, 1993. The appropriation for Title I is $325.5 million. The CARE Act requires HRSA to make Title I formula grant awards to EMAs within 60 days after funds are appropriated, which is Monday, December 20, 1993. Title I EMAs must submit an application for FY 1994 formula funds within 45 days after the appropriation is signed, which is Monday, December 6, 1993. The specific dollar amounts for individual formula awards will be finalized in two to three weeks.

The deadline for submitting FY 1994 supplemental Title I CARE Act grant applications has been changed from January 7th to Friday, January 14, 1994. Grants will be awarded within 150 days of the date funds were appropriated, which is Monday March 21, 1994, with an effective start date of April 4, 1994.

ATTACHMENT TWO

Yvonne Frazier
915 Hillcroft Circle
Oakland, California 94103
(415) 974-9049 (Voice)

November 3, 1993

Mr. James Loyce
Co-Chairperson
Ryan White HIV Services Planning Council
25 Van Ness
San Francisco, California 94102

Dear Mr. Loyce:

I am resigning from the Ryan White HIV Services Planning Council effective November 16, 1993.

I accepted a new position on October 1, 1993, (San Francisco Target City Director-CSAS) and I confronted the reality that I have a finite amount of energy, have my hands full with my new assignment, and had to a prioritize my activities.

It has been a pleasure serving on the council for the past three years and I have the utmost respect for council members, the AIDS Office, and the accomplishments of this body.

Please call upon me if I can be of any assistance to you or the Ryan White Council in the future. I selected the date of November 16 so that I can finish commitments such as review of annual reports.

Sincerely,

Yvonne Frazier

cc: Council Members
Charles Brand

Marin County

ATTACHMENT THREE

SUPPLEMENTAL REQUEST

Case Management 2.64 FTE Salary, benefits, supplies, travel etc.	$128,150
Client Advocacy 1.0 FTE Benefits Advocate Salary, benefits, supplies, travel etc.	$39,150
Food Service Salaries, food, supplies and equipment	$75,700
TOTAL REQUEST	**$243,000**

NEW FORMULA MONIES

Housing R.N./attendants and other support services		$250,000
Complementary Services		$65,000
1 FTE herbalist/acupuncturist	$35,000	
Herbs/vitamins/supplies	$30,000	
Women's Services Including child care/transportation/gyn. care		$35,000
Substance Abuse Treatment Residential and day treatment		$125,000
Dental Assistance		$10,000
Home Health Care		$25,000
TOTAL REQUEST		**$510,000**

Health Services Agency
AIDS PROGRAM

BOARD OF SUPERVISORS
RUBEN BARRALES
MARY GRIFFIN
TOM HUENING
TED LEMPERT
MICHAEL D. NEVIN

COUNTY OF SAN MATEO

MARGARET TAYLOR
DIRECTOR OF HEALTH SERVICES

3700 EDISON STREET • SAN MATEO • CALIFORNIA 94403 TELEPHONE (415) 573-2588

Sophia Chang
San Francisco AIDS Office
25 Van Ness Avenue, Suite 500
San Francisco, CA 94102

November 5, 1995

Dear Sophia:

The San Mateo County AIDS Program Community Advisory Board, which functions as the Ryan White CARE Act planning body for San Mateo County, has completed its CARE-related planning for FY 1994-1995. This included a review of relevant information, priority setting, and assignment of potential funds to prioritized service categories. The process included a review of the following information:

Client Satisfaction Survey
Client Focus Groups
Provider Focus Groups
EMA-Wide Client Needs Assessment Survey
Advisory Board Committees Needs Assessments
Advisory Board Committees Recommendations
AIDS Program Staff Recommendations
Advisory Board Client Satisfaction Committee Discussions
Epidemiological Data
Contract Agency Input
Survey of Women Clients

Advisory Board committees which provided input to this process included: Client Satisfaction; HIV and Chemical Dependency; Housing; and Services for Women, Children, and Adolescents.

We have attached to this letter the San Mateo County proposal for use of Title I Formula and Supplemental Funds for FY 1994-95. San Mateo County had 6.9% of the total persons living with AIDS in our EMA as of March 31, 1993. Based on this percentage, we are proposing to utilize 6.9% of total EMA Formula funds, $1,331,700, and an equal amount of potential Supplemental funds. Thus, we are requesting a total of $2,663,400. We have also described the use of Title II funds in this proposal. Assuming flat Title II funding, the San Mateo County Title II allocation for FY 1994-1995 will be $103,194.

This funding will permit us to maintain current CARE-funded services and to expand services in critical areas of unmet need.

On behalf of the Advisory Board and the persons living with HIV it serves, we want to thank the San Francisco HIV Health Services Planning Council for this opportunity to request Title I Supplemental Funds for FY 1994-95.

Sincerely,

Noel Leca
Chair
AIDS Community Advisory Board

A. Gene Copello
Director
AIDS Program

cc: Margaret Taylor, Director, Health Services Agency

SAN MATEO COUNTY AIDS PROGRAM
RYAN WHITE CARE TITLES I AND II
CURRENT AND SUGGESTED FUNDING

The following are the recommendations of the San Mateo County AIDS Program Advisory Board in regard to the disbursement of Ryan White I Formula monies and a request for supplemental monies. Each item includes a 5% indirect cost rate for the AIDS Program and, when it is believed the service will be contracted out to another agency, includes a 9% indirect cost rate for the contracting agency.

I. PRIMARY MEDICAL CARE (INCLUDING EARLY INTERVENTION)

Current: Ryan White I and II funding for outpatient primary medical care and early intervention covers salaries for a total of 10 FTEs: 1 nurse practitioner, .75 physician's assistant, 2.5 nurses, 1 LVN, 2 medical service assistants, .5 pharmacist, .25 volunteer coordinator and 2 support staff. It also covers approximately $83,000 in operating expenses including contracted time for a nutritionist and medical transcription, laboratory, medical supplies and equipment and general operating costs.

Two funding streams for primary care/early intervention are suggested for FY 1994-1995:

1. Augmentation of Current Program: Increased staffing totalling 4 FTEs is requested: 1 nurse manager, .5 phlebotomist, 1 infectious disease fellow/resident, 1.5 support positions in order to maximize potential third party reimbursement for medical services. One of the support positions will be assigned to Health Services Accounting. In addition, an augmentation of funds for operating expenses such as the contract nutritionist, laboratory costs, medical and pharmaceutical supplies and equipment, and general operating expenses is sought. It is anticipated that approximately 50 additional clients can be served with this augmentation, and more units of service can be provided to the existing client/patient base.

2. Health Outreach Team: 1.5 FTEs is requested to fund health outreach workers to facilitate the entry of persons with HIV disease into the medical care/early intervention system and to provide for follow-up of clients remaining in the community but lost to clinical services. It is anticipated that approximately 100 new or follow-up clients will be brought into clinical services out of approximately 350 persons with HIV with whom the team members will have contact.

II. HOUSING

No housing is currently funded through Ryan White I or II monies. The current housing program is funded through monies from the Housing Opportunities for Persons With AIDS (HOPWA) program. These funds are contracted to the Mental Health Association (MHA) as the housing component of the Housing and Client Assistance Project.

Additional Funding: Two housing programs using Ryan White Money are suggested for the upcoming year.

1. Belmont House: Approximately $215,000 to provide program, operating expenses and indirect costs for the house being developed by the City of Belmont as a residential facility for persons with AIDS. Included in this funding are 5 FTEs and operating expenses excluding renovation, rent and ongoing maintenance which will be provided by the City of Belmont. The positions include 1 housing project director, 3 residential assistants and 1 housing activity coordinator. It is estimated that personnel costs will be approximately $158,400. The remainder of the $215,000 will be for operating expenses and indirect costs.

   It is anticipated that there will be a Request for Proposals (RFP) for this service. The house will have six beds and it is projected that approximately 10 individuals will receive the service in a year.

2. Rent Subsidies: As a supplement to the HOPWA funding, $114,450 is requested for rent subsidies. This will make it possible to extend the 21 week limit for subsidies under the HOPWA funding for approximately 20 clients.

III. FOOD

Currently the AIDS Program has a client assistance program which is contracted out to the Mental Health Association (MHA) as part of the Housing and Client Assistance Project. MHA subcontracts the client assistance portion to ELLIPSE. Total funding for the client assistance subcontract is currently $75,500. Although the subcontract has several components to it, food is the primary service unit in the form of food vouchers and/or grocery bags and/or nutritional supplements. A .75 FTE is funded with the money as well as some clothing vouchers, bus vouchers, and emergency assistance.

An approximately $107,694 augmentation of this program is requested to increase the total funding to $183,194 for the services outlined in the above paragraph as well as other food services such as hot delivered meals. It is anticipated that an additional 100 unduplicated clients can be served through this augmentation. A request for proposals for this service will be developed early in 1994.

IV. DENTAL

No dental services are currently provided utilizing Ryan White monies except occasionally through utilization of client assistance monies. Approximately $180,000 is requested to provide dental services and transportation to those services plus a 9% indirect cost rate for the contract provider. It is anticipated that 150 clients will be served with the addition of this program.

V. MENTAL HEALTH

Ryan White monies are not currently used for mental health services. However, through monies from the Mental Health Division, a psychiatrist is funded for 4 hours per week to provide direct patient care, medication monitoring and psychiatric consultation to the AIDS Program Clinic staff. Approximately $49,200 is requested for the purposes of contracting out in-house mental health services. This will provide for mental health counseling, assessment, and staff consultation for approximately 100 clients and 500-600 units of service.

VI. CASE MANAGEMENT

In addition to the State funded Case Management Project (nurse, brokerage model) contracted out to the Division of Aging and Adult Services and the State Early Intervention Project's nursing case management, the AIDS Program has a social services case management program funded by Ryan White I monies including: 2.75 FTE staff plus operating expenses which include funding for the Drop-In Center, mileage reimbursement and general operating costs. The staff funded include 1.5 social workers, .25 volunteer coordinator and 1 support person.

An augmentation of the AIDS Program's case management program is requested which would add 3.25 staff plus operating expenses including rent for the Drop-In Center, if required, depending on the short-term future of the current AIDS Program site. The additional staff would include 2 social workers, 1 community program specialist and .25 volunteer coordinator. The addition of two social workers would decrease the social worker:client ratio from 1:175 to 1:100 and allow for the provision of approximately 2,000 additional units of service.

VII. SUBSTANCE ABUSE

Currently no Ryan White monies are used for substance abuse services. A small amount of HOPWA money has been used to provide limited residential substance abuse treatment and 10 hours a week of a substance abuse counselor are provided through monies from other grant sources.

Ryan White monies are requested in FY 1994/1995 for funding three substance abuse programs:

1. Outpatient Methadone Maintenance: Approximately $46,000 would be used to pay for 10 Methadone maintenance slots.

2. Substance Abuse Treatment: Approximately $194,000, including indirect costs, would be used purchase slots in various modalities of substance abuse treatment, including residential treatment, medical detoxification, etc., for up to $6,600/year for a minimum of 26 clients.

3. Substance Abuse Counselor: Approximately $57,225 is requested to cover the cost of a contract for a full-time substance abuse counselor, plus indirect costs. This counselor would provide assessment and counseling services to clients of the San Mateo County AIDS Program, facilitate the admission of clients into substance abuse treatment programs, and would act as consultant to AIDS Program contract agencies who provide services to clients with substance abuse problems. It is estimated that between 75 and 100 new and existing clients would be served under this contract.

VIII. HOME HEALTH

The AIDS Program contracts to Aging and Adult Services (AAS) for nursing case management, including home health, for its more disabled clients. The following service will be provided by AAS for these and other eligible clients with HIV disease:

1. Attendant Care and Support: Approximately $161,521 would be used to fund 1 FTE nurse case manager, .5 FTE social worker, attendant care hours, client support supplies such as ensure, assistive devices, etc., and indirect costs. It is estimated that 25 additional clients would receive this service.

2. Attendant Training: Approximately $25,000 would be used to recruit and train a pool of home health care attendants specifically for persons with HIV disease. If the contract agency is able to accomplish this in the current fiscal year, these monies would be used for attendant care (1 above).

IX. CLIENT ADVOCACY

Other than monies spent on case management, which has included some client advocacy services, no money has been designated specifically for this service area. Requested at this time is the funding for two programs:

1. Eligibility Worker: Funding for one full-time benefits analyst, plus operating expenses and indirect costs, for the amount of $47,000. This program could be located in the AIDS Program proper or could be subcontracted out to a community based agency or other County program. However, service provision would need to be at all three AIDS Program sites for at least part of the time.

2. Representative Payee Program: Approximately $50,000 would be required for the Division of Aging and Adult Services to establish and run an HIV specific representative payee unit.

ATTACHMENT FOUR

GAY MEN OF COLOR
ADVOCATES FOR

NATIONAL TASK FORCE ON AIDS PREVENTION

631 O'Farrell Street • San Francisco • California • 94109
415/749-6700 • FAX 415/749-6706

November 1, 1993

Ms. Sophia Chang, MD
Chief, Health Services Branch
SF DPH AIDS Office
25 Van Ness Avenue, Suite 500
San Francisco, California 94112

Dear Sophia:

I would like to take this opportunity to nominate Estella Garcia as Co-Chair to replace me in my former capacity serving the CARE Planning Council. I believe Estella can bring a wealth of knowledge, insight and equity to the council and its proceedings. Her community experience is well suited to this process and shows qualities of which the city of San Francisco can be proud.

I would also like to recommend that we move forward in bringing on board additional people living with HIV. This will facilitate the continued input and involvement of communities affected by this disease.

Yours in the struggle,

Reggie Williams
Former Co-Chair

RW/ajm

SF
H22
#1
11/22/93

HIV HEALTH SERVICES PLANNING COUNCIL

DOCUMENTS DEPT
NOV 18 1993
SAN FRANCISCO
PUBLIC LIBRARY

November 22, 1993

25 Van Ness Ave., Third Floor Conference Room

4:30 to 7:30 p.m.

AGENDA:

I. Roll Call

II. Review of October 25th Meeting Minutes and Agenda

III. General Announcements

IV. Subcommittee Reports

V. Discussion of Ark of Refuge

VI. Impact of EMA Funding Decisions on Overall CARE Budget

VII. Schedule & Process for Review of Grant Expenditures

VIII. Timeline for Grant Development & Review

IX. Public Comment

DECEMBER MEETINGS

December 13, 1994

25 Van Ness Avenue, Third Floor, 4:30PM – 7:30PM

HIV HEALTH SERVICES PLANNING COUNCIL

November 22, 1993

The Minutes of this meeting are missing.

San Francisco Public Library
Government Information Center

HIV HEALTH SERVICES PLANNING COUNCIL

December 13, 1993

The Agenda of this meeting is missing.

San Francisco Public Library
Government Information Center

ST
422
#2
12/13/93

HIV HEALTH SERVICES PLANNING COUNCIL

December 13, 1993
25 Van Ness Avenue, Third Floor
4:30 - 7:00 p.m.

MINUTES

DOCUMENTS DEPT.
JAN 6 1994
SAN FRANCISCO
PUBLIC LIBRARY

MEMBERS

Present: Gene Copello, Marey A. Fraser, Yvonne Frazier, Jaime Geaga, Lester D. Hanson, Gerald Lenoir, Gifford S. Leoung, James Loyee, Kent Maedonald, Jr., Scott Miller, J.B. Molaghan, Bob Nelson, Elliot S.Ramos, Steve Roger, Geoffrey, Sackett, Laura Thomas, Rita Times, Reggie Williams, Mary Jane Wood.
Absent: Pat Christen, Barbara Gareia, Estela Gareia, Susan Karp, Steve Lew, Mike Shriver, Jerry Windley.

STAFF: Mitch Katz, Bill Haskell, Joseph Cecere, Valerie Dorr, Galen Leung, Judith Weld, C. Brand.

I. Roll Call

Roll eall was taken as above. Marey A. Fraser served as temporary eo-chairperson. Aecordingly, she did not vote on resolutions during the meeting.

II. Review of Minutes and Agenda

The following correetion was made to the minutes of the meeting of November 22: on page 2, "Health Work Team" should read "Health Outreach Team." The minutes as revised and the Agenda of Deeember 13 were a e-eepted, with Gerald Lenoir abstaining.

III. General Announcements

The Planning Council welcomed new members Gene Copello and Geoffrey Saekett at this, their first official meeting sinee appointment by Mayor Frank Jordan.

Valerie Dorr distributed "summary reports" of three meetings eonvened by the Health Resourees and Serviees Administration (HRSA) this past summer (*see Note One].* A fourth *Summary Report*, on a meeting with national providers held in the fall, has not been published yet. Many of these topies will be diseussed by the Counеil in January, and HRSA is using the information as it designs its approaeh toward reauthorization of the CARE Aet.

☹James Loyee, Jr., Council eo-chair and Assoeiate Direetor of the AIDS Offiee, announeed that he has been offered the position of exeeutive direetor of AIDS Projeet Los Angeles. If he aeeepts the position, his last day with the AIDS Offiee will be January 7. The Counеil expressed its pleasure at his possible leadership of one of the leading private, non-profit HIV serviee providers in the United States.

IV. Subcommittee Reports: Subcommittee on Evaluation Concerning Reallocation of One-Time Funds

Laura Thomas reviewed the recommendations of the Subeommittee. The funds should not be used for programs on the CARE Supplemental list that could not be reached otherwise, since Title II alloeations ean be used to fund them. The Subeommittee proposed that the estimated $1.2 million in unexpended funds be used as follows:

$400,000	--Pharmaeeuticals, speeifieally psyehotropie; and non-HIV drugs that Medi-Cal will not eover;
$100,000	--Speeial Planning Counеil projeets;
Remainder	--(Est. $700,000) One-time projeets of eurrent eontractors.

The Subeommittee recommended that the Council designate a working group to investigate pharmaeeutieal serv-iees for HIV patients at San Franeisco General Hospital, and suggest ways to improve the system. Laura Tho-mas, Marey Fraser and Steve Roger will eonstitute the working group. Mr. Roger noted that 54 pharmaeies

mas, Marcy Fraser and Steve Roger will constitute the working group. Mr. Roger noted that 54 pharmacies throughout San Francisco were now participating in the drug distribution program. J. B. Molaghan observed that the changes still had not decompressed the situation at the hospital, especially for non-HIV-related drugs, and clients should be able to receive efficient service on-site. Dr. Mitchell Katz suggested that the working group investigate how the AIDS Drug Assistance Program (ADAP) has been advertised. Some service providers are unaware of it. Valerie Dorr said that AIDS Office program manager for ADAP, Michelle Dixon, will attend the next Council meeting to report on the progress of advertising and medication delivery programs.

Mr. Roger reported that DDC was added to the ADAP Formulary on December 1. Hopefully 12 more will be added by April 1. The Title II Working Group approved the transfer of an additional $3.5 million to the program. With anticipated rebates, there should be sufficient funds. Mr. Roger will provide a presentation on ADAP at the January 3 meeting. Ms. Fraser requested that Michelle Dixon join him.

The $100,000 set-aside for Planning Council projects could include more technical assistance for contractors, similar to that now funded through the Support Center. The Council might wish to hire a consultant to assist with long-range planning.

The Subcommittee recommended a $50,000 cap per project and agency -- as the Council did last year -- so that at least 14 awards can be made from the estimated $700,000 remaining; requiring each applicant agency to be at the level of 90% UOS (UOS) and 75% unduplicated clients (UDC); use of the funds for salaries be permitted; and that the final list remain in effect for 12 or even 36 months. Projects further down the list would be funded as new funds become available. Valerie Dorr explained the lower UDC requirement. New contractors often overestimate the volume of services clients will require. As a result, they are lower on their UDC estimate and higher on their UOS.

Ms. Dorr noted that some of these funds are from Year One. Precise amounts should be available December 31. Additional funds will become available April 30, when Formula contractors submit final invoices; and still more on June 30, from the Supplemental contractors. More immediate is the surplus of funds resulting from underexpending by some contractors. Rather than waiting until they are reported as an unliquidated balance on a contract at the end of the year, the AIDS Office is encouraging contractors to identify these amounts as early as possible. Last year agencies returned significant amounts at the end of their contract, due to vacant staff positions and similar causes

Q.: Must these one-time grants be expended within a specific budget period?
A.: In the past, the one-time expenditures had to be made within our regular contractual period. However, since HRSA is allowing us to roll money from one year to the next, we may not have to do that. Ms. Dorr will ask HRSA for a final determination. Since the funds will be transferred to grantees by contract modification, it makes sense that expenditures such as one-time purchases fit within the respective Formula or Supplemental period. If the funds are used for salaries, the term might be extended.

Laura Thomas made the following motion:

> **That unexpended funds (estimated at $1.2 million) be used as follows: $400,000 for pharmaceuticals; $100,000 for special projects designated by the Planning Council; and the remainder (est. $700,000) for one-time allocations, each with a $50,000 cap, to current contractors who meet the performance criteria of 90% units of service and 75% unduplicated clients.**

The motion was seconded. During the discussion, Dr. Mitchell Katz asked if the $50,000 cap offered the opportunity to make a big difference for any one agency. His discussions with contractors indicated that there might be *bona fide* projects needing more than $50,000. The Council should consider inviting agencies to discuss their

needs. Gerald Lenoir asked if a specific situation existed, to guide the Council in its decision. Dr. Katz noted that the situation did exist. If he had known that the Council was going to set a cap this evening, he would have obtained permission from the agencies to provide specific information about their requirements. Mr. Lenoir also asked how many agencies would actually meet the eligibility criteria being proposed. Ms. Dorr responded that quite a few agencies are providing units of service within the 90 -- 200% range.

Mary Jane Wood asked if a higher cap would lead agencies to expect a proportional increase in support on an ongoing basis. Let them seek this kind of increase from an augmentation in either Formula or Supplemental funds in next year's funding. Reggie Williams said that contractors know how the Council handled one-time funds last year, and anticipate the same structure this year. Gerald Lenoir felt that a higher cap amounted to an augmentation. Any major item should have been included in an agency's proposal.

J. B. Molaghan proposed $100,000 cap per award. The underestimate for home infusion services demonstrated the speculative nature of pricing and cost projection. One-time grants can serve a significant role as emergency funding, and let the Council assist agencies that did not anticipate changes in service demand or costs. Dr. Katz suggested that a $150,000 cap would provide the needed flexibility, and that the Council must require applicants to state that they would not need that amount the following year. J. B. Molaghan then proposed a cap of $150,000 per award.

Valerie Dorr noted that any letter to the contractors would go out over the signature of the co-chairpersons, and must be reviewed and approved by the Council.

Scott Miller asked if the awardees would receive the funds in a reasonable amount of time. Dr. Katz responded that augmentations were generally not difficult to add to contracts.

The following motion was made, seconded, and approved unanimously:
A>

That unexpended funds (est. $1.2 million) funds be used as follows: $400,000 for pharmaceuticals; $100,000 for special projects designated by the Planning Council; and the remainder (est. $700,000) for one-time grants, with a $150,000 cap, to current contractors who meet the performance criteria of 90% units of service and 75% unduplicated clients.

Working Group for Transition of Services Previously Provided by Health Outreach Team

Elliot Ramos reported that the working group recommended transfer of the funds to Tom Waddell Clinic (TWC) rather than issuing a new RFP. Services must be provided off-site and reach the clients who needed them. J. B. Molaghan added that the group did not consider Ward 86 (San Francisco General Hospital) to be an adequate alternative, although many of these clients eventually receive medical care there. It was important to keep the focus on street advocacy in the Tenderloin area. The program must be based at a separate site, so that It does not get enmeshed in TWC's daily functioning. Many in the target population already receive health services there. Another very important factor was the speed in resuming the services. Dr. Katz said that TWC fully agreed to have an outreach nurse practitioner or physician assistant in the streets, based at a location a few blocks from the HOT location. TWC could begin services quickly with as-needed nurse practitioner time, to minimize the delay of processing a full-time requisition.

Reggie Williams stressed that the staff must be sensitive to the needs of the target population and know how to reach them. Dr. Katz noted that TWC currently has an outreach effort in the Ambassador Hotel and several others. Dr. Teresa Black has been very active and effective in the HIV Homeless program, and provides medical care currently in the Tenderloin. Mr. Ramos said that the group wanted assurance that a certain percentage of the program worker's time would be "on the streets." Mr. Molaghan added that the group expects certain guarantees about how the position is recruited.

Mary Jane Wood asked about HOT's case management component. Dr. Katz responded that TWC now provides social work services and many health services that the clients require. HOT, with no connection to a medical clinic, was unable to provide these efficiently. TWC staff providing the service could also deliver case management in the streets. If funds permit, a social worker could provide case management services. The emphasis must remain a very medically oriented case management, since there were other case management programs in the Tenderloin.

J. B. Molaghan made the following motion, which was seconded and passed unanimously, without opposition or abstention:

B>

That the unexpended funds of the original allocation to the Health Outreach Team be transferred to the Tom Waddell Clinic, to create a new service which will provide outreach and advocacy within the Tenderloin area at an off-site location. The Working Group for the Transition of Services Previously Provided by the Health Outreach Team must review and approve the proposed site, program scope, and job descriptions prior to approval of the contract.

V. Clarification of Acting Health Services Branch Administration

Bill Haskell distributed the current organization chart of the Branch (*see Note Three*). Until the "Branch Chief" position vacated by Dr. Sophia Chang is filled, he and Valerie Dorr are dividing all responsibilities. Ms. Dorr is responsible primarily for the department, grant management and personnel, as well as budgetary issues. Mr. Haskell is responsible for CBOs and the Planning Council, and still is responsible for AIDS housing and CARE services planning. Both are developing the CARE application, with consultant Paul Gibson. Mitchell Katz, MD, AIDS Office Director, is the temporary administrator for CARE.

Q: What is the "Clinical Services Coordinator" position?

A: Agencies have requested increased technical assistance around some of the medical and nursing issues, and the AIDS Office lacks the staff to fill this urgent need. The position will also have supervisory responsibility for the AIDS Reimbursement Program, providing the clinical management emphasis that is missing now.

VI. Support Center -- Final Copy of Client Survey

Mike Allison of the Support Center described the changes that had been made to the draft of the client survey presented to the Planning Council on October 11, 1993 (*see Note Two*]. The study has been renamed (*Voices of Experience*), and incorporates changes proposed by the Council and other reviewers. There is more emphasis on clients opinion and more quotation. A large literature review and appendices have been added. Members received the "Executive Summary" section, which highlights the new emphases.

Critiques by Bob Nelson and AIDS Office staff will be incorporated, along with comments from Dr. Sophia Chang, Steve Lew and Estela Garcia. The Council will review the study after it is revised, and decide how to use and publicize the information.

VII Update on Community Housing Activity

Bob Nelson reviewed the recent community planning for AIDS housing. There have been numerous meetings and extensive community involvement. The AIDS Office--Planning Council--Redevelopment Agency cooperation is producing tangible results. The meetings and the assistance of the Corporation for Supportive Housing and the Seattle consultants will result in a Comprehensive HIV Housing Plan that the Council may receive in February or March. Bill Haskell said that after the Council approves it, the Plan will go to the Redevelopment Agency, Health Commission, Board of Supervisors and the Mayor for universal buy-in. This is the City's issue.

This year the HOPWA allocation will increase 50%, to $9 million. There is extensive maneuvering to disrupt the association of CARE and HOPWA funding, by transferring the planning process from HOPWA to a consolidation of other HUD Formula grant programs. This would make any Planning Council role in AIDS housing subject to the approval of the local jurisdiction. Meetings were held with HUD Assistant Secretary Andrew Cuomo. The Council will be asked to support the effort to keep the planning and application parts of HOPWA separate.

VIII. Review of New Contractor Checklist

The Council did not take up this matter.

IX. Need for Planning Council Participation in Review of CARE Application

The AIDS Office is writing the CARE application with consultant Paul Gibson. The initial draft, to be completed on December 21, will be read by Mary Jane Wood. Laura Thomas and Geoffrey Sackett will review the proposed final version on January 7, 1994.

X. Summary of Response to CARE RFP for FY 1994-1995.

Judith Weld discussed the RFPs for new CARE-funded services, that were received by the December 1 deadline. The preliminary logistics are as follows:

Service Category by Council Priority	*Proposals*	*Planning Council Allocation*	*RFP Requests*
1.Primary Medical Care	7	$ 1,050,000	$ 1,690,313
2.Housing & Housing Related Services	4	$ 2,250,000	$ 2,563,583
3.Food Bank/ Delivered Meals	3	$ 750,000	$ 819,399
4.Dental Care	2	$ 825,000	$ 770,176
5.Mental Health/Counseling	13	$1,125,000	$ 3,176,471
6.Case Management	10*	$ 825,000	$ 1,921,061
7.Substance Abuse Treatment	9	$ 2,850,000	$ 2,810,341
8.Home Health Care	5	$ 1,500,000	$ 1,957,224
9.Client Advocacy	6	$ 900,000	$ 1,258,258
10.Direct Emergency Assistance	2	$ 300,000	$ 313,060
11.Alternative/Complementary Care	8	$ 450,000	$ 808,461
12.Buddy/Companion Services	4	$ 600,000	$ 478,271
13.Residential Hospice Care	None	$ 600,000	None
14.Rehab Care	2	$ 150,000	$ 83,758
15.Day & Respite Care	1	$ 450,000	$ 280,000
16.Transportation	None	$ 75,000	None
17.Translation/Interpretation	1	$ 75,000	$ 75,000
18.Adoption/Foster Care	None	$ 75,000	None
TOTAL:	*77*	*$14,850,000*	*$19,005,365*

*An eleventh Case Management proposal was received. The requested amount is still unclear.

Ms. Weld noted that no proposals were received for three service categories, only one was disqualified; and for the first time, none was submitted after the deadline. Family Service Agency of San Francisco's was disqualified because the agency did not meet all the eligibility requirements The review teams will meet this week and next week to evaluate and score the proposals. The Council will receive their recommendations in January.

Q.: How will the Council handle those categories for which no proposal was received? A.: The Council can choose to set aside funding and issue another request for proposals. That would depend on how much money is received in CARE Supplemental funds, and how far down on the priority list those categories fall.

Ms. Fraser noted that tonight was the last Council session before Ms. Weld leaves the AIDS Office, and expressed the appreciation of the Council for the services she has provided.

XI. DPH CARE Proposal -- Follow-up.
Dr. Katz reported that the CPHS request for $45,000 in medical records equipment was deleted, since it was not sufficiently AIDS care-specific. San Francisco General Hospital (SFGH) was told to use the security and housekeeping positions only on Wards 86 and 4C, and that the Council would observe this. SFGH is deciding whether to use a psychiatric technician instead of an institutional police officer. Valerie Dorr is working with Sylvia Villareal to prepare a budget proposal for enhanced pediatric AIDS services at SFGH, which will include a half-time nurse practitioner or physician assistant, and a quarter- or half-time social worker. This will be given priority over other SFGH CARE proposals

Gifford Leoung asked how SFGH could demonstrate it was actually provide 3,000 *additional* C.T. scans for HIV+ clients. Would they establish a baseline? While scan requests from certain wards would indicate HIV status, HIV+ persons referred by outlying clinics, Family Health, Medicine, Pediatrics, etc., might not be counted. Ms. Dorr suggested cross-checking various computer references the Hospital has against the actual scans performed -- assuming that they were billable and that they were coded and thus have a diagnosis. Dr. Katz suggested intensively scrutinizing subportion of the scans to derive a percentage of identifiable HIV+ clients, and then extrapolated that figure to the entire amount of scans to derive a reasonable baseline. Ms. Dorr noted that ancillary services often have documentation difficulties in their quarterly reporting.

XII. Issues related to Reauthorization of CARE Act. This item was not considered.

XIII. Public Comment
Gail McBride, coordinator of adult mental health contracts for the Family Services Agency of San Francisco [FSA], asked the Council to reverse the disqualification of its proposal for new CARE service. On December 2 the AIDS Office informed the Agency that its proposal was ineligible since as of September 30 FSA had not met 50% of projected UOS for its current contract. Ms. McBride said that a corrected quarterly report indicated that the UOS was 56%. FSA discussed this with their AIDS Office program manager and referenced it in the narrative of their proposal. Various operational factors caused the low figure on the original quarterly report as well as the delay in correcting it.

Elliot Ramos noted that FSA had from October 15 until December 1 to submit a corrected report. Dr. Katz and Valerie Dorr said that the eligibility requirements and screening process were carefully reviewed at the bidders conference and in the written instructions. Galen Leung noted that FSA's billings were checked, and they reflected less than 50% UOS. If an exception is made to the rules, the entire process must be reopened. The delays might prevent the AIDS Office from meeting the January 14 grant application deadline. Bill Haskell noted that the AIDS Office program manager advised FSA to correct its quarterly report before the December 1 deadline, and they failed to do so.

NOTES: (1) Health Resources and Services Administration, Division of HIV Services, *Ryan White Title I Constituency: Discussion Group Meeting, July 9-10, 1993: Summary Report*, 18 pp.; *Persons Living with AIDS: Community Discussion Group Meeting, July 19-20, 1993: Summary Report*, 13pp.; *Ryan White Title II: Constituency Discussion Group Meeting, August 9-10, 1993: Summary Report*, 15 pp..
(2) The Support Center for Nonprofit Management, **What do the Clients Say?: Assessing Client Experience with HIV-Related Health and Supportive Services in San Francisco** [Draft], (San Francisco, 1993), 65 pp.
(3) AIDS Office, *Health Services Branch: AIDS Office: 19 November 1993.*